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School Refusal Behavior: From Terminology to Treatment

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Abstract

School refusal is broad term that encompasses a child motivated refusal to attend or remain at school. Many externalizing and internalizing behaviors are associated with school refusal, including tantrums, aggression, noncompliance, anxiety, depression and somatic complaints. The heterogeneity of both the behavioral presentation and terminology of school refusal make classification difficult, however there are common comorbidities such as separation anxiety disorder, major depressive disorder, and social or specific phobia. It is proposed that school refusal behavior is maintained by four possible functions: escape, avoidance, attention, and tangible rewards. These four functional profiles have received continuous empirical support, and offer prescriptive treatment heuristics. This monograph analyzed prevalence, etiology, assessment and treatment from this perspective.

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Description and prevalence

School refusal is a broad term that encompasses a child motivated refusal to attend or remain at school, or a clear and apparent difficulty in doing so (Kearney, 2008). This refusal often results from anxiety produced either by the separation from a major attachment figure or from fear of an aversive situation at school such as bullying or an oral presentation. School refusal can also result from positive reinforcement, or rewards, such as access to television, video games, or simply attention that is received outside of school.

The main condition of school refusal is severe difficulty attending or remaining in school, resulting in prolonged absences. From this core symptom there can result both internalizing and externalizing behaviors (Kearney & Albano, 2000). Internalizing behaviors include anxiety, depression, fear, fatigue, and somatic complaints. Externalizing behaviors include tantrums, aggression, clinging, noncompliance, refusing to move and running away. Some situations can preclude the term school refusal, such as a legitimate illness or disorder. Also, if the refusal is parent motivated rather than child motivated, the term school withdrawal is more appropriate than school refusal. Finally, there are certain societal or familial conditions such as vacations, homelessness, economic reasons, or running away from an abusive environment that make the term school refusal inappropriate (King, Ollendick & Tonge, 1995).

School refusal can have a negative impact on multiple areas of functioning. In the short term, school refusing children are at risk for decreased academic performance, increased stress, alienation from peers, family conflict, and a decrease in supervision (Kearney & Albano, 2000). This decrease in supervision is also a risk factor for illicit activity and legal trouble. The long term outlook of school refusing youth includes a heightened risk for economic deprivation, marital problems, substance abuse, criminal behavior and poor psychosocial functioning.

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Because school attendance is a critical component of our social and academic development, these potential risks are compounded by the duration of the school refusal (King, Tonge, Heyne, Turner, Pritchard, Young, Rollings, Myerson & Ollendick, 2001).

It is normal to want to stay at home, and many children will refuse to go to school a few times throughout their lives. The difference between this “normal” tendency and substantial school refusal is that the latter generally involves absences of at least two weeks. School refusal is thought of as acute if it occurs between two weeks and one year, and chronic if it spans two consecutive academic years (Kearney, 2007). Acute school refusal is common for younger children and children who have recently moved or experienced a large change in their home environment. Chronic school refusal is more readily observed in adolescents, but is harder to treat.

Because precise criteria for school refusal have not been well established, it is difficult to determine accurate prevalence rates. Although 28% of children may refuse school at some point, estimates of those who display chronic school refusal are around 0.4% (Granell de Aldaz, Vivas, Gelfand, & Feldman 1984; Heyne, King, Tonge, & Cooper 2001). School refusal peaks at ages 5-6 and 14-15, however the mean age falls around 10. Overall, school refusal is equally distributed among gender, socioeconomic status (SES), and intelligence (Kearney & Albano 2000). There are, however, some demographic variables that are associated with specific subtypes of school refusal. For example, children with a low SES tend to be more anxious or fearful of social elements of school (teachers and peers), whereas those from higher SES's are more afraid of evaluative situations such as grades and exams. Further, school refusal with or resulting from separation anxiety seems to be comprised of more females, while school refusal associated with a specific phobia seems dominantly male (King, Ollendick, & Tonge 1995).

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Classification and terminology

The Diagnostic and Statistical Manual (DSM-IV-TR) does not have a specific code for school refusal. However, many children who demonstrate this behavior may meet classification criteria for an anxiety or affective disorder (American Psychiatric Association, 2000). The most common disorders in which school refusal is seen include separation anxiety, specific or social phobia, and major depressive disorder (King, Ollendick, & Tonge, 1995). Due to the heterogeneity of school refusal, and the wide spectrum of behavioral problems associated with it, it is difficult to classify as a single, specific condition.

Finding the most appropriate title of school refusal behavior compounds the difficulty of classification. In the literature, terms such as school phobia, school refusal and truancy are all used to describe a similar condition. In the past, school phobia was the favored term, as it captured those who clearly presented anxiety and physiological arousal while refusing school. However, this term did not account for those who refused school to gain access to positive reinforcement. School truancy is a different subtype of school refusal as it most often does not result from intense anxiety or fear, and because it does not come into play until later adolescence. Also, in most situations of school refusal, the parents are aware that their child is not at school, while truancy implies that the whereabouts of the child are unknown. School refusal is a broad term that can include the most categories, and that is why it has been the predominant term used in recent literature. This paper will use school refusal as an all encompassing term.

Functions

School refusing behavior is thought to be maintained by two functions, negative and positive reinforcement. From these two main functions, four profiles have been proposed (Kearney & Albano, 2004). Each profile represents a different set of behaviors, and knowing

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which profile the child fits can be useful in determining what course of treatment to take.

Although there will be very few times when a child shows behaviors from only one profile, to know the primary reason that school refusal is being maintained is very helpful to therapists, parents and teachers for information regarding comorbid conditions and treatment guidelines (Kearney, 2002; Kearney & Albano, 2000; see Table 1).

The first profile is the child who refuses school to avoid school related objects and situations. This profile is most congruent with a child who has a specific phobia, such as a fear of the playground or of fire alarms. In this profile, by staying home the child avoids something that he or she is afraid of. The next profile includes the child who stays home to escape aversive social and evaluative situations, such as presentations, exams, or reading out loud. This profile of school refusal may be more difficult to detect, since oral presentations and tests do not always follow a regular schedule. In each of these profiles, the school refusing behavior is maintained by negative reinforcement, which means that even though they aren't receiving a tangible reward, they are being excused from a situation or environment they dislike and given the chance to go to one that they prefer.

The third profile represents the child who refuses school to receive attention from a primary caregiver. This profile includes children with separation anxiety, and by refusing school these children are often allowed to remain with their major attachment figure. Finally, the fourth profile describes the individual who receives tangible rewards while refusing school. These rewards will vary based on the individual, but they frequently include access to television and video games, treats at home, or even illicit substances. School refusal depicted by these profiles is maintained by positive reinforcement, meaning by refusing to go to school the children gain access to a preferred person, object or activity.

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Table 1: Functional profiles of school refusal. Adapted from "When Children Refuse School: A Cognitive-Behavioral Therapy Approach," by C.A. Kearney and A.M. Albano, 2000, p. 3-5.

Functional Profile	Description	Associated Conditions	Prescriptive Treatment
1: Avoidance	To avoid school-related objects or situations that cause general distress/negative affectivity	Generalized anxiety disorder; specific phobia; panic disorder; emotional disturbance; depression; agoraphobia	Psychoeducation; exposure; systematic desensitization; self reinforcement
2: Escape	To escape aversive social and/or evaluative situations at school	Social phobia; depression; social issues or anxiety; shyness	Psychoeducation; role play; modeling; cognitive therapy; social skills groups
3: Attention	To receive attention from significant others outside of school	Separation anxiety disorder; oppositional defiant disorder; noncompliance	Parent training; contingency management; differential reinforcement
4: Rewards	To pursue tangible reinforcement outside of school	Oppositional defiant disorder; conduct disorder; substance abuse	Contingency contracting; response cost

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Etiology

The origin of school refusal shows heterogeneity similar to its behavioral presentation. Different factors that may influence the development of school refusal include a genetic predisposition, the home and family environment, the school environment and social pressures, as well as learning theories that emphasize the role of social reinforcement and modeling (King, Ollendick, & Tonge, 1995). It is possible that the four functions of school refusal may have distinct patterns of contributing factors, however this research is only in the early stages (Kearney, 2007).

A genetic predisposition is an inborn vulnerability that would place a child at higher risk for anxiety or emotional disturbances. Essentially, some expression of the genetic code makes these children more susceptible to developing school refusal behavior in response to anxiety or fear provoking situations. This may be seen more dominantly in the first three profiles; avoidance, escape and attention seeking (Kearney & Albano, 2000). Temperament is another genetic factor that has been implicated in school refusal. Emotional reactivity, activity level, mood and adaptability are components of temperament that can influence how we handle difficult situations. Finally, separation anxiety has been shown to have a weak genetic component (Doobay, 2005; Masi, Mucci, & Millepiedi, 2001). This means that if someone in the child's family has difficulties with anxiety, the child may be a greater risk to develop separation anxiety, and in turn more likely to refuse school.

The home environment can be a cause of significant stress, and this stress can result in school refusal behavior. For example, moving to a new house or city may mean changing schools. This can be very difficult on children, especially if they did not want or expect to change. As a result, they may refuse to go to the new school as a way of fighting that change

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(King, Ollendick, & Tonge, 1995). Family stress can also play a role in school refusal.

Illnesses, accidents, operations or deaths within the family can be a cause of acute school refusal, which may develop into chronic refusal if the child gains access to reinforcement from not attending school. Another consideration of the home environment is any marital conflict or parental psychopathology. These issues can lead to school refusal because they cause stress to the child, and also have an impact on parenting practices. Worse still, they can impact the effort and willingness of the parents to find solutions and resources for their child's school refusal. In these situations, it is important to find a therapist who understands how to work with the parents as well as the child (Kearney & Albano, 2000).

Although school factors are more straightforward, there is a substantial number of potential problems. Tests, homework, social pressures, bullying, and public speaking can all be sources of anxiety or fear leading to school refusal. The problem lies in understanding which factor is responsible for the refusal behavior. Bullying, homework, and social pressures can be consistent or daily, whereas tests, presentations and public speaking are less frequent. This is when soliciting the teacher is most helpful, as they can provide a schedule of homework, tests, and presentations while also giving insight into the classroom dynamic. If there is an issue of bullying, there is a good chance the teacher knows about it, or can at least make an educated guess. Using information from both the child and the teacher should be a priority in determining the cause of school refusal (Kearney & Albano, 2000).

Learning theories can also be used to understand the initiation and maintenance of school refusal. Most of these theories focus on the role of reinforcement, however there is also a social learning theory that includes modeling and shaping of behavior (King, Ollendick, & Tonge, 1995). For example, mothers are often seen as a safe place during early childhood development.

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If the mother seeks to overprotect every time the child faces an anxiety or fear producing situation, that child may develop a separation anxiety that leads to school refusal.

Separation anxiety is a specific condition that can cause school refusal, but children with elevated levels of general anxiety are also at risk. It has been found that anxious children tend to make more negative self statements and negative evaluations during an anxiety producing situation (Doobay, 2008). These negative cognitions can exacerbate school refusal behavior, as well as predispose the child to depression. In these cases, it may be very difficult to determine the specific cause of school refusal, but treatment should include targeting and changing these negative cognitions.

Fear can be learned through direct conditioning, vicarious conditioning (modeling), or the transmission of fear messages (King, Ollendick, & Tonge, 1995). A fear of school and school related stimuli can be developed in a child by watching their older siblings or friends display a fear reaction (modeling), or simply by listening to their parents discuss a fearful element of school (transmission of fear messages). While it is possible to develop a strong fear simply by observations or based on accounts of others, it seems that direct conditioning is more likely to be involved in fear-based cases of school refusal (King, Ollendick, & Tonge, 1995). This type of learning includes the child experiencing the feared situation or stimuli his or herself. This experience can lead to the development of a specific phobia, which would propagate the avoidance of that stimulus. If the stimulus is within the school environment, school refusal behavior may follow.

Assessment

There are various methods for assessing school refusal behavior in children, ranging from a straightforward records review to a functional analysis of the behavior. Starting simply, a

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records review provides valuable information regarding dates of attendance and school referrals.

This is a basic step in determining the frequency of school refusals as well as potential factors that contribute to school absence. From this, interviews with parents, children, and teachers provide multiple perspectives on the nature and severity of the school refusal. Some suggested measures include:

- Children's Assessment Schedule (CAS): The CAS is a clinical assessment designed to serve as a diagnostic instrument for a wide array of disorders (Hodges, 1978).
- Diagnostic Interview Schedule for Children (DISC): The DISC is a structured interview designed to assess psychiatric disorders and symptoms in children (Costello et al., 1984).
- Diagnostic Interview for Children and Adolescents (DICA): The DICA is a structured interview based on DSM-IV symptoms and a broad range of behavioral problems (Herjanic & Reich, 1982).
- Anxiety Disorders Interview Schedule for Children (ADIS-C): The ADIS-C is a semi-structured interview that focuses on anxiety disorders, with attention to school refusal (Silverman, 1991).

Behavioral rating scales should also be given to teachers and parents to obtain their unique ideas and perspectives on the problem. These scales are able to capture a broad representation of the child's behavior, and can be taken from multiple sources. Because fear and anxiety are subjective experiences, a self report measure is very useful in understanding what the child is feeling. These types of assessments can also help determine the underlying cause of school refusal and how to focus treatment. As stated above, the three most common conditions associated with school refusal are anxiety, fear and depression, which leads to the following self report measures:

- Fear Survey Schedule for Children, Revised: This scale purports to differentiate between school phobia and separation anxiety through five fear factors. Fear of the unknown is associated with separation anxiety, while fear of failure and criticism is more characteristic of school phobia (Ollendick, 1983).
- Children's Manifest Anxiety Scale: Gives three anxiety related factors (physiological, worry/oversensitivity, concentration). This scale is more useful in determining the course or target of intervention (Reynolds & Richmond, 1985).

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- Children's Depression Inventory: Negative affect can be common for school refusal, especially for separation anxiety, however again this measure is more useful for formulating treatment aims (Kovacs, 1992).

Behavioral observations combined with self monitoring techniques are very useful in the identification of antecedents that may contribute to school refusal. Using trained personnel to observe the school refusal sequence can be helpful in detecting unseen antecedents that set the stage for the behavior, as well as the consequences that maintain it. Self monitoring provides a report of how the child is feeling and their attributions of the behavior. The advantage of self monitoring is that it gives a direct report of what the child is doing and thinking, and can occur in situations such as the home where a behavioral observation might not be feasible. Unfortunately, as with many self report measures, the reliability of self monitoring can be an issue.

While the above measures will each provide various, potentially critical information regarding school refusal, the best strategy for formally assessing the behavior is a functional analysis (King, Heyne, Tonge, Gullone, & Ollendick, 2001). A functional analysis is a method for identifying the function that any given behavior serves, as determined by the antecedents and consequences of that behavior. A descriptive functional analysis uses information provided by the child and child's parents based on past occurrences of the behavior. An experimental functional analysis entails real life observation of the behavior in various settings. While experimental functional analysis can provide the therapist or professional with more detailed and accurate information, it is often infeasible. For this reason, Kearney and Silverman (1993) developed the School Refusal Assessment Scale, which provides a descriptive functional assessment in conjunction with the four primary functions of school refusal (avoidance, escape, attention, rewards).

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The SRAS is designed to measure the relative contributions of the four functions of school refusal. There are 16 items, and four items are matched to each function. The items are ranked on a 6 point scale, ranging from never to always. Ideally, the parents and child would both complete the SRAS-P and SRAS-C, respectively. This process takes about ten minutes, and can be extremely helpful in determining the underlying cause of the behavior. The scores are averaged, and the highest scoring function can be considered as the primary reason for the child's refusing school. However, due to the heterogeneity of school refusal behavior, it is likely that more than one scale will be elevated. Although this makes drawing firm conclusions regarding the primary function of the behavior difficult, knowing each of the contributing factors is important in deciding treatment methods and aims.

If possible, conducting an experimental functional analysis following the administration of the SRAS will provide the strongest and most accurate treatment recommendations (Kearney & Albano, 2000). Following the descriptive analysis, there should emerge some hypotheses regarding the function of the school refusal behavior. By taking those hypotheses and manipulating the environment to test and observe them in their natural setting, the therapist can affirm or disprove the hypothesized function of the behavior, resulting in increased treatment specificity.

Treatment

Although treatment will be different for every child, the main goal of any treatment is to return the child to school. However, some considerations must be taken before beginning any consultation or psychological treatment. In terms of the child, some factors that may influence treatment include a medical investigation, presence of traumatic life events, comorbid problems or disorders, temperament, self esteem, social status and physical status (Kearney & Albano,

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2000). Considerations concerning the parents include parental psychopathology, marital or family conflict, parenting style, financial resources and attitude toward treatment (Kearney & Albano, 2000).

At a global level, the school arrangement and degree of cooperation between school and therapist is another factor to consider before beginning treatment. Schools often blame the home, and vice versa, but the school is a crucial component in the treatment procedure (Kearney & Albano, 2000). In order to return the student to school, some changes may have to be made to facilitate this transition. The degree of involvement from the school will also depend on the child's age and primary reasons for refusing school.

Since the development of the four functional profiles of school refusal, prescriptive treatment plans now exist and are receiving growing empirical support (King, Heyne, Tonge, Gullone, & Ollendick, 2001). Once a functional profile is found to be the primary contributor to the school refusal behavior, the prescriptive treatment plans offer a simplistic program for that functional profile (see table 1). These prescriptive treatments utilize evidence based cognitive and behavioral methods to alleviate the fear or anxiety associated with school, or they attempt to combat the positive reinforcement provided by either attention or tangible rewards. These treatments are designed to provide a heuristic approach, however every treatment program should be tailored to the individual child or family. This section will focus mainly on these treatments provided by Kearney and Albano (2000), followed by a short summary of other treatments which have been used historically.

Profile 1: Avoidance

Treatment for children who refuse school as a method of avoidance of school based stimuli should focus on changing that stimulus so that it no longer produces a feeling of dread,

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fear, or anxiety. Some elements of this treatment include building an anxiety/avoidance hierarchy of specific stimuli, teaching relaxation skills to help decrease somatic arousal, and conducting systematic exposure to the desensitize the child to the stimulus.

Anxiety/avoidance hierarchy: An anxiety/avoidance hierarchy is a table that includes space for a situation or object and a place for the child to rate it both in terms of the amount of anxiety it produces and the degree to which they avoid it. To create an anxiety/avoidance hierarchy, the therapist should compile index cards with situations or objects that the child fears or avoids.

Once presented to the child, the therapist can ask him or her to rank them in terms of how they feel about that situation or object. Some education may be necessary for the child to understand the anxiety or fear process, but it will have great benefit in both understanding what makes the child refuse school and how to direct treatment. When the child is ready to begin systematic exposure, the therapist can begin with the item that causes the least amount of anxiety and work his or her way up the hierarchy.

Relaxation Training: There are many different methods of relaxation training available. While many of these are well established techniques, a combination of progressive muscle relaxation and deep diaphragm breathing is preferred. Deep diaphragm breathing is achieved by inhaling through the nose and exhaling through the mouth. Progressive muscle relaxation is a technique in which a muscle group is isolated and contracted for five seconds, and then released. You can start with any muscle group, but the process should be linear (e.g. feet to head to hands, hands to head to feet).

Systematic desensitization: Systematic desensitization is the process of gradually introducing a feared stimulus in a small, stepwise fashion. A stimulus is presented to the child in imaginal form, often just the thought of the stimulus in the beginning stages. The child is instructed to

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raise his or her hand once the level of anxiety becomes excessive. As treatment continues, more realistic representations of the stimulus are introduced as the child learns to cope with them.

Once the child is comfortable with any imaginal representation of the stimulus, it is possible to introduce *in vivo*, or real life desensitization, in which the child is placed in the context of that stimulus. Rather than listening to or viewing descriptions of the stimulus, the child and therapist role play the situation. The process continues in the same stepwise fashion, slowly increasing the realism of the stimulus until the child no longer experiences anxiety in the presence of that stimulus. Because this is such a delicate process, it is important to begin it only after teaching relaxation and coping strategies, as well as reviewing the anxiety and avoidance hierarchy, beginning desensitization with the lowest stimuli.

Profile 2: Escape

Children who refuse school to escape situations in which they are being evaluated (e.g. oral reports, public speaking, taking a test) often feel extensive amounts of anxiety in these situations, so much that it makes them unbearable. Treatment for these children should identify any negative cognitions or thoughts they may have, teaching coping mechanisms to change those thoughts, and gradually exposing them to the anxiety producing situations.

Identifying negative thoughts: Depending on the age of the child, a STOP program can be useful in determining what negative thoughts occur and in what situations. STOP is a acronym with four components: S- am I feeling Scared?, T-what am I Thinking?, O- Other helpful thoughts, and P- Praise for using this model and Plan for next time. If a child is younger, simply imagining a stop sign can be helpful in decreasing anxiety. Once any negative thoughts are identified, they can be labeled and targeted.

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Challenging and changing negative thoughts: Once the negative thoughts are identified, the therapist and child or adolescent must work together to change them. One commonly used strategy is to ask questions that can help refute negative and anxiety provoking thoughts. These questions can include challenging the likelihood of the feared situation, questioning if the person actually knows what others are thinking, or determining the most realistic consequence or outcome of a situation. It will be important to practice a variety of these types of questions, as they apply to different situations.

Behavioral exposure (role playing): Exposure is a process of imagining a stressful situation and acting it out with another person. For treatment of school refusal, the therapist and the child or adolescent will decide upon a situation that produces anxiety. It is best to start with mild situations and gradually progress into more feared situations. During these role plays, the therapist should help the child practice the STOP techniques to cope with any anxiety they may be feeling. By going through a variety of these anxiety producing situations, the therapist can help the child understand his or her own negative thoughts, and develop a way to cope with or challenge them. The overall goal of these sessions is that once confronted in the real world, the child will still possess the coping strategies and be better suited to handle the situation.

Profile 3: Attention

Children who refuse school for attention often exhibit noncompliance and disruptive behaviors, clinging, tantrums, refusing to move, and guilt inducing behavior. Treatment for these children differs from the previous two profiles in that it is focused on parent education and training, as opposed to child-focused strategies. Namely, prescriptive treatment for these individuals involves restructuring parent commands, establishing routines, and setting up punishments and rewards for school attendance.

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Changing parent commands: In some cases of school refusal, the child who is seeking attention is extremely adept at negotiations, and is often able to change rules and guidelines set by parents. This treatment component focuses on eliminating these negotiations by providing parents with simple and specific commands. For most cases, a list is made of commands issued by the parents that are commonly refused by the child. This list is then expanded on to include when the command should be carried through, reducing the command to its simplistic form, and ensuring that nothing will interfere with that command. Parents are also trained to deliver the request in command form, as opposed to a question, and eliminate criticism and excessive speaking. This kind of training will establish the requests as commands that need to be followed, and not optional chores that can be negotiated. This component is combined with effective consequences and rewards described below.

Establishing routines: Having a routine makes a child's day more predictable, which can limit behavioral outbursts. In establishing routines, parents are asked to make a detailed schedule of the day (every 10 minutes) that they spend with their child. It is common that there is no regular schedule, and in this case a general outline can still be beneficial. From this, the parents and therapist work to create a basic routine for all activities. The morning routine is most relevant to going to school, and as such should be the primary focus, however it will be of benefit to have regular routines for all parts of the day to limit non-compliance. Having a more rigid schedule can promote a smooth transition to school. Once a routine is set and the child is used to it, consequences can be instated for deviation from the routine.

Setting up punishments and rewards: This treatment begins with the parents listing what disciplinary actions and rewards have been used in the past, and how successful they were. Then, with the help of the therapist, appropriate consequences and rewards are selected. After

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this, another list of negative and positive behaviors is made, and these behaviors are ranked in order of severity. Then the parents and therapist match punishments and rewards to the negative and positive behaviors, respectively. Because this child is assumedly refusing school for attention, it is helpful to include ignoring negative behavior and praising positive behavior as consequences. Attention should be paid to what consequences seem to work, but a special emphasis should be directed to the consistency with which the consequences are applied.

Profile 4: Rewards

Children and adolescents who refuse school to pursue tangible reinforcement outside of school are often secretive about their refusals, and may demonstrate behaviors such as aggression, running away, disruptive behavior, and substance use. Again, like the child refusing school for attention, treatment in this area is focused on immediate and relevant family members. The goal of this treatment is to improve problem solving within the family through contingency contracting.

Contingency contracting: The first step in contingency contracting is setting up a specific time and place to negotiate problems. This will help prevent arguments and disputes from erupting at undesirable times. Setting time aside also shows a commitment to problem solving and a desire to improve communication within the family. The next component involves clearly defining the problem behavior and related influences from both the parents and the child's perspective.

These perspectives will often be very different, and will require a compromise for everyone to agree on the behavior. After the target behavior has been clearly defined, a contract should be developed that is satisfactory to both parents and child. This contract will include rewards and punishments for how the child follows through with the behavior. Each contract should be considered final, but there can be a progression of contracts throughout therapy, each with more

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complex behaviors and consequences. It is generally best to start simple and small to ensure that every party is willing to participate in the treatment. Once the contract is designed, every member of the family should read and be familiar with it before they sign it. It is important that any disagreement regarding the contract be addressed prior to implementation. Once signed, each family member should be given a copy, and a master copy should be placed somewhere where the family can see it. As therapy progresses, new contracts will be continuously made, to the point that the child or adolescent is able to attend school with little encouragement and family members are able to communicate and problem-solve any issues that may arise.

Alternative treatments

There are many variations of the above treatments, however most successful programs use similar procedures (e.g. emotive imagery, shaping, modeling). Treatments that are not based within a cognitive behavioral perspective have found some success, although only a minority of children who refuse school have shown large treatment gains from these alternatives.

Counseling from a psychodynamic perspective is a potential treatment for school refusing children, particularly those with separation anxiety (King, Ollendick, & Tonge, 1995). This type of counseling aims to increase the distance between the child and the primary attachment figure, generally the mother. While this was historically a common treatment, it has since become less prevalent. It is a costly and time-consuming treatment, and gains from therapy generally occur very slowly. Also, this type of treatment does not apply to those refusing school to obtain tangible rewards.

Forced attendance can include either escorting the child to school or placing them in an inpatient or residential treatment center. Using an escort to take the student to school is still commonly used, however it does not treat the function of the behavior and therefore will only

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work as long as it is in place (Kearney, 2000). Moreover, forcibly taking a child to school when they would not go otherwise can provoke more anxiety and worsen the child-school relationship. It is recommended that once a child begins to make improvement they are reinstated in school, but not dragged forcibly against their will. Residential and inpatient treatment centers require patients to attend classes, however these settings are more appropriate for those refusing school that have comorbid disorders, behavioral problems, or noncompliance (King, Ollendick, & Tonge, 1995). These programs also commonly use the cognitive behavioral methods discussed above.

A final treatment that has been tried in the past is psychotropic medication. Some of the medications that have been used historically include antidepressants, anxiolytics, neuroleptics, and stimulants. The primary use of these medications was to reduce anxiety and fear, and to a minor extent depression. While these medications may treat the symptoms, they do not treat the underlying behaviors which are likely to remain without supplemental treatment. Prior to beginning any pharmacotherapy, the following list of conditions should be met: the child should present specific symptoms known to be relieved by a specific agent, and the agent with the fewest side effects; there should be a comprehensive psychiatric evaluation; the child's symptoms must cause significant distress; safer and less invasive methods should be tried first; and the prescribing psychiatrist must monitor and supervise the effect of medication carefully (King, Ollendick, & Tonge, 1995). Ideally, medications should only be used in combination with other types of therapy, and only when the child demonstrates severe anxiety or depression.

Longitudinal studies

The long term outcome for children who refuse school is not well established, primarily due to the lack of a consistent definition. Regardless of the terminology used, school refusal may

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be a precursor to disturbances later in life, and this effect is moderated by many variables (Tyrer & Tyrer, 1974). The severity of the behavior, age of onset, intellectual functioning of the child and time before treatment are just some primary variables that can affect the long term outcome for school refusal.

There are a few long term studies that provide mixed results. A three year follow up by Berg (1976) reported three roughly equal outcomes. One third of children treated for school refusal showed little or no improvement, and demonstrated emotional disturbance and impaired social functioning. Another third showed moderate improvement, but were still affected by anxiety and depression. The final third made substantial improvement and had little to no difficulty attending school and normal social functioning. According to Berg, the best indicator of future outcome was the clinical condition upon discharge.

This work is similar to other outcome studies that indicate school refusal is likely related to other psychological or psychiatric disorders. One study found that, although matched on most indices, those who demonstrate school refusal have more psychiatric care visits than a control sample (Flakierska-Praquin, Lindstrom, & Gillberg, 1997). Further, another study found that school refusal was associated with general neurotic disturbances, although not necessarily agoraphobia (Tyrer & Tyrer, 1974).

Case study

Derrick was a 13 year old male at the time of referral. His teachers and school authorities referred him to an anxiety treatment center after a substantial decrease in performance and school attendance. By the eighth week of classes, Derrick had missed six full days of school, 10 out of 40 algebra classes and 13 out of 40 physical education classes. Moreover, many of these absences had occurred within the last two weeks, as Derrick five out the last ten days of school,

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six out of ten algebra classes, and eight out of ten physical education classes. Derrick's teachers reported that despite his absenteeism, he was a good student although he was not well liked.

A short background history revealed that Derrick's parents were divorced when he was nine months old, and he had been living with his mother and her parents from that point on. Derrick's mother reported that his father, parental grandfather and paternal uncle were alcoholics. She did not report or present any psychopathology, however her mother (Derrick's grandmother) had been diagnosed with major depressive disorder. Derrick's mother also stated that he had a history of being wary regarding new people or situations, and had difficulties transitioning from kindergarten to first grade and again from elementary school to middle school. She reported that although Derrick had never presented any problems with separation from her, he had a clear preference for solitary activities.

Derrick presented as a moderately overweight and frightened boy. During the initial assessment, he displayed some signs of anxiety, including a reluctance to speak, avoidance of eye contact, and pleading with his mother to stay in the room. Derrick reported that his main difficulties with school involved changing for gym class and having to write on the board in algebra class. During gym class the other boys teased him and called him names, and he was afraid of getting the wrong answer in algebra class. Gym and algebra were also Derrick's first two classes of the day.

On days when Derrick would refuse school, he would wake up upset and ask to stay at home. When he was told he couldn't, he would become more upset. His mother would have to leave to go to work, and his grandparents were unable to get him on the bus. A deal was made that they would drive him after his second class was over, but this did not always work. His

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mother was also ineffective at getting him to school, despite phone calls and a 21 mile return from work on two of the days.

Derrick was given the ADIS-C, SRAS, Children's Fear Survey Schedule-Revised, Revised Children's Manifest Anxiety Scale, and the CDI. Copies of both the SRAS and Revised Behavior Problem Checklist were also given to Derrick's mother and teachers. Responses to these measures indicated that Derrick met diagnostic criteria for avoidant disorder, social phobia, and overanxious disorder, and did not meet criteria for separation anxiety disorder or major depressive disorder. Derrick reported specific fears regarding Failure and Criticism, including "looking foolish," "being teased," "being criticized by others," and "doing something new." On the SRAS Derrick presented elevated scores for avoidance and escape, which was also reported on the parent and teacher SRAS.

The goal of treatment was to get Derrick back in school full time within two weeks. In the initial treatment program, Derrick was seen 10 times, twice a week for the first two weeks, and once a week for the following six. A behavioral contract was designed and agreed upon in which Derrick would be able to miss his first two classes for the first three days, his first class only for the next three days, and would attend all classes the following four days. Reinforcers were determined for achieving these goals and returning to school within the two week time frame. This progressive program is a means of graduated exposure, as each step involves more time or interaction with the feared stimuli.

To assist in this exposure procedure, Derrick was taught relaxation techniques including progressive muscle relaxation, as well as positive coping statements to counteract any negative cognitions and appraisals he may have. Additionally, he was taught some assertive responses

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that could be used in situations when he was being teased. During treatment, the therapist would model these statements and afterward Derrick would role play them.

Derrick was successful for the first six days, however he refused to go to school on the day he was to attend gym class. On that day, his mother returned from work and took him to school after his second period class. During therapy that day he practiced his relaxation techniques and positive self statements until he felt competent that he could attend the full day of school. Derrick attended school the next day and experienced very little teasing in gym class. From this point on, he was able to ride the bus and attend every school day, with the exception of two days in December with a legitimate illness. The following semester, Derrick was able to attend the first day of class, but experienced many of the apprehensive feelings he had felt before. He was praised for his courage to remain at school, and being able to control these feelings. The next check up was scheduled for December, and then another one month following. At both of these follow ups, Derrick was attending school and doing well.

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