



CHAPTER 1

UNDERSTANDING SCHOOL REFUSAL

Cody fights with his mother every morning before school. He hides under his bed, refusing to come out. Eventually his mother has to carry him to the car only to endure another round of kicking and crying in the school parking lot. Cody's third grade teacher tries to prevent his running out of the classroom when his mother leaves the building.

School refusal behavior presents challenging and often agonizing scenarios for parents, students, and teachers. While initial or occasional apprehension regarding school attendance is regarded as normal, a significant problem occurs when anxiety results in refusal to attend school (King, Ollendick, & Tonge, 1995; Ollendick & Mayer, 1984). School refusal refers to primarily emotionally based absenteeism initiated by the child and includes children who exhibit extreme anxiety surrounding school attendance, usually the result of an anxiety disorder (Burke & Silverman, 1987; Last, Hansen, & Franco, 1998; Last & Strauss, 1990). The broader term, school refusal behavior, includes children with emotionally based school refusal described above as well as those traditionally referred to as truant (Kearney, 2001; Kearney & Silverman, 1996). As such, school refusal behavior is defined as a repetitive pattern of nonattendance initiated by the child which may involve missing school for full days, part of the day, or school attendance only after severe acting out with the intention to miss school (Kearney, 2001).

The task of defining and classifying school refusers is difficult because school refusers are a heterogeneous group of children who experience an array of internalizing features such as separation anxiety, social anxiety, and depression (Bernstein & Garfinkel, 1986, 1988; Bernstein et al., 1997; Last, Francis, Hersen, Kazdin, & Strauss, 1987; Last & Strauss, 1990). For some school refusers, externalizing behaviors are present and are manifestations of severe anxiety (Kearney, 2001). For example, like Cody, panic at being separated from a caregiver results in acting out behaviors such as screaming, clinging, or kicking. Additionally, there are several variables that contribute to or exacerbate school refusal behaviors. Contributing variables to school refusal include family pathology, victimization, poor teacher-student relationships, or academic difficulties (Kearney, 2001; King et al., 1995).

TERMS ASSOCIATED WITH SCHOOL REFUSAL

Anxiety-based school refusal refers to children who experience extreme anxiety surrounding school attendance. Over the years, researchers have used many terms to describe these children. Terms associated with anxiety-based school refusal are “psychoneurotic truancy,” “school phobia,” and “school refusal.”

Early psychodynamically oriented writers used the term “school phobia” to refer to extreme anxiety surrounding separation from a parent, usually the mother (Johnson, 1957). However, use of the term school phobia has been described as inaccurate when what is really being referred to is a child’s separation anxiety. More precisely, the term school phobia refers to a fear of school or something associated with school (e.g., the school building, the fire alarm) whereas separation anxiety refers to a child’s difficulty separating from one or both parents (Burke & Silverman, 1987). Additionally, the term school phobia suggests the presence of a specific phobia toward a school situation that may be present for some children yet for others may more accurately be described as social or performance anxiety (Kearney & Beasley, 1994).

Indeed, there has been growing recognition that emotionally based school avoidance can be the result of not only separation anxiety but features such as social anxiety and depression. Accordingly, the more inclusive term, “school refusal,” began to be used by some practitioners and researchers because it encompasses the wide range of etiologic and interacting variables that result in attendance problems (Burke & Silverman, 1987; King et al., 1995). For example, the impetus for an adolescent who stays home to avoid giving a speech is related to performance anxiety. This scenario differs from the child who balks at going to school because of a fear that something bad is going to happen to a parent. Yet for both students, the demands for school attendance create intense anxiety and avoidance responses. The term school refusal is used here to refer to emotionally based school avoidance (i.e., primarily the result of anxiety or depression).

The primary focus of this book will be anxiety-based school refusal though a wide range of etiologic variables and associated intervention strategies will be covered.

Children with anxiety-based school refusal have historically been identified as distinct from those students exhibiting characteristics associated with delinquent truancy. Delinquent truancy refers to students who skip school without their parent's knowledge and engage in delinquent behaviors. These children lack the emotional difficulties typical of children identified as having anxiety-based school refusal. Similarly, the term "truancy" is defined as unexcused absence without parent's knowledge (Berg et al., 1985) in the absence of somatic complaints with poor academic progress, and possible antisocial behavior (Pilkington & Piersel, 1991). Additionally, the term truancy is sometimes used by school personnel to refer to unexcused absence from school in violation of compulsory attendance laws regardless of the reason for the absence (e.g., emotional, motivational, or delinquent).

Kearney (2001) points out that some children exhibit emotionally based school refusal combined with the traditional conceptualization of truancy (e.g., Bernstein & Garfinkel, 1986). An example of this combination would be an adolescent who displays comorbid depression and anxiety as well as oppositional behaviors. Features may include a pattern of refusing to get out of bed in the morning, a sense of pervasive unhappiness, panic-like symptoms when verbal participation is required in class, frequent arguing with parents, and skipping classes to hang out with friends and experiment with drugs. In these situations, school refusal represents the tip of the iceberg when educators sift through the many variables that often present as a crisis point for student and family. As previously discussed the term, "school refusal behavior," includes anxiety-based school refusal, behaviors traditionally associated with truancy, or both (Kearney, 2001).

A final term to consider is "school withdrawal." School withdrawal refers to situations where a parent or legal guardian purposely keeps a child home. In these cases, the reason for keeping a child home is initiated by the parent. School withdrawal initiated by the parent includes using a child as a support person for a parent who is anxious and/or depressed, sabotaging efforts to reintegrate a child who has been absent due to school refusal, or requiring a child to work to help with finances (Berg et al., 1985; Kearney, 2001). Table 1 on page 4 summarizes terms and definitions associated with school refusal and truancy.

PREVALENCE RATES

Attendance officers, school secretaries, and school nurses are often among the first to recognize students who are frequently absent or tardy. Teachers will recognize patterns of

TABLE 1

TERMS ASSOCIATED WITH SCHOOL REFUSAL AND TRUANCY

Term	Definition
Psychoneurotic truancy	Once described anxious children who had difficulty separating from an overprotective parent (Partridge, 1939).
School phobia	First used to describe children with excessive anxiety attending school brought on by separation anxiety (e.g., Johnson, Falstein, Szurek, & Svendsen, 1941). Later clarified to refer to a fear of school itself or a phobic reaction to some aspect of school (Burke & Silverman, 1987).
Separation anxiety	Refers to “excessive anxiety concerning separation from the home or from those to whom the person is attached” (American Psychiatric Association, 1994, p. 110).
School refusal	Refers to children who exhibit severe emotional distress about attending school usually due to anxiety.
Truancy	Refers to children who miss school in violation of compulsory school attendance laws. Absence from school is unexcused, generally without the parent’s knowledge, and may involve delinquent behaviors.
School refusal behavior	A broad term used to refer to behaviors associated with both emotionally-based school refusal and truancy (Kearney, 2001).
School withdrawal	Refers to when a parent removes a child from school that may be due to a parental need (e.g., the child is the support person for an anxious or depressed parent, to cover up signs of maltreatment, or the student is required to work to help with family finances).

absentee behavior quite quickly, and parents can provide pertinent information related to why their child misses or is late for school. Interestingly, parents do not always communicate why their child is absent or tardy. For instance, a student who stayed home because of a stomachache related to anxiety about school may be reported simply as ill, or students who complain to parents about going to school and attend only with prodding or battles may go entirely uncounted in prevalence rate estimates. Additionally, since it is sometimes difficult to distinguish between anxiety-driven school refusal and truancy, prevalence rates have historically been difficult to compile.

In 1965, Kennedy estimated the school phobia prevalence rate to be at 1.7%. Later, Granell de Aldaz, Vivas, Gelfand, and Feldman (1984) surveyed 1,034 Venezuelan children ages 3–14 years. When they combined high absenteeism with either parent, teacher, or child report of extreme fear associated with school, 5.4% of the sample could be considered school refusers. A lower rate of 0.4% was reported when using a stricter criteria requiring that all three informants report extreme fear of school combined with high absenteeism.

Burke and Silverman (1987) reviewed prevalence rates of school refusal and found a rate of 1% in the general population of school age children and approximately 5% of children referred to clinics. Clinical prevalence rates reported by Kearney and Beasley (1994) were only slightly higher at 6.08%. This sample included responses from 63 professional psychologists.

A survey of 288 school principals in North Dakota by Stickney and Miltenberger (1998) found an estimated 2.3% of students in grades kindergarten through 12 engage in school refusal behavior. This survey did not distinguish between truancy and emotionally based school refusal (the presence of anxiety or depression).

Kearney (2001) compiled comprehensive data on four broad-based components of school refusal behavior. He concluded that when anxiety-based school refusal estimates (1.7–5.4%) were combined with truancy-related estimates (complete and illicit absence from school, partial absence-class cutting, tardiness) roughly 5–28% of children display some aspect of school refusal behavior.

Researchers worldwide have studied school refusal, contributing to an extensive accumulation of literature on the topic. Extensive research has been conducted in England (e.g., Berg & Jackson, 1985; Berg, Nichols, & Pritchard, 1969; Blagg & Yule, 1984; Hibbett & Fogelman, 1990). Studies have also been conducted in Australia (e.g., King et al., 1998); France (Martin, Cabrol, Bouvard, Lepine, & Mouren-Simeoni, 1999); Sweden (Flakierska, Lindstrom, & Gillberg, 1988); and Venezuela (Granell de Aldaz et al., 1984). Though rates are

lower in Japan than in the United States, researchers in Japan report concern that the number of students exhibiting school refusal is increasing with more than 127,000 cases reported in 1998 (Kameguchi & Murphy-Shigematsu, 2001).

SUBTYPES AND FEATURES OF SCHOOL REFUSAL

The extreme heterogeneity of this population has led to ongoing attempts to refine classification systems. The resulting array of diagnostic models reflects the complexity of this undeniably diverse group of children. Typically, researchers have assigned subtypes as a framework for classification of school refusal behavior. The earliest subtypes made the distinction between acute versus chronic school phobia and school phobia versus truancy.

Subtyping continues to be practiced by contemporary researchers approaching school refusal behavior from functional, categorical, and dimensional perspectives. A functional approach addresses the function or reason behind school refusal behavior. A categorical approach is geared toward classification of emotional or psychological characteristics of students such as social and separation anxiety or depression. A dimensional approach examines internalizing versus externalizing behaviors. A working knowledge of multiple diagnostic perspectives is critical for school psychologists seeking to understand the impetus for a student's school refusal.

ACUTE AND CHRONIC DISTINCTIONS

A distinction between acute and chronic school refusal was made by Coolidge, Hahn, and Peck (1957), who grouped children with school phobia into two subtypes: neurotic and characterological. Younger children comprised the neurotic group, where school phobia onset was sudden and intense with panic-like symptoms. Older children comprised the characterological group, where symptoms developed gradually, the result of a "deeper character disturbance existing from an early age" (p. 297). With both types, the mother was thought to encourage dependency in the child. This fostering of interdependency was considered more pathological on the part of the mothers of the characterological type, whose symptoms were thought to be part of a more complex personality disorder (Paccione-Dyszlewski & Contessa-Kislus, 1987).

Kennedy (1965), expanding on the concept of subtyping school refusal based on severity, identified 10 symptoms that differentiated between what he termed Type 1 and Type 2 school phobia. Type 1 represented younger children with first episode, acute onset, and for the most part well adjusted and understanding parents. Type 2 represented older children, second, third, or fourth episode school refusal, "incipient onset," and "parents very difficult to work with" (p. 286). Type 1 cases were reportedly responsive to rapid treatment and may have spontaneously improved without treatment.

A continuum of severity using length of time absent from school was developed by Kearney and Silverman (1996). The continuum is useful with all types of school refusal scenarios. It recognizes that some mild cases of school refusal spontaneously remit while others present as long-term problems that last more than one year. A kindergartner's school refusal due to separation anxiety that resolves itself within two weeks with minimal intervention would be considered self-corrective school refusal. A high school student's one year on and off absences due to depression and social anxiety would be placed on the acute end of the continuum. Chronic school refusal is defined as lasting longer than one year.

Exclusionary factors are important considerations and include legitimate illness, situational hardships such as homelessness or running away to avoid abuse and children whose parents keep them home as in cases of school withdrawal (Kearney & Silverman, 1996). Additionally, a parent may keep a child home from school for a period to cover up signs of abuse. Other parents opt to home school their child as a last resort after weeks or months of trying unsuccessfully to get their child to go to school.

ANXIETY-BASED SCHOOL REFUSAL VERSUS TRUANCY

As was previously discussed, a distinction is often made between anxiety-based school refusal and truancy (Berg et al., 1985; Berg et al., 1969; Gordon & Young, 1976; Hersov, 1960; King et al., 1995). In 1969, Berg et al. proposed criteria for school refusal that clearly distinguishes emotionally based school refusal from truancy and continues to be used by some researchers (e.g., King et al., 1998):

- *Severe difficulty in attending school*—often amounting to prolonged absence.
- *Severe emotional upset*—shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause on being faced with the prospect of going to school.
- *Staying at home with the knowledge of the parents*, when they should be at school, at some stage in the course of the disorder.
- *Absence of significant anti-social disorders* such as stealing, lying, wandering, destructiveness and sexual misbehavior. (p. 123)

As illustrated here, children with anxiety-based school refusal typically are not involved in anti-social behaviors and do not conceal their absences from their parents. They exhibit distress surrounding school attendance and frequent physical complaints. Studies investigating large groups of school refusers support the premise of two distinct subgroups of students who avoid school: students with emotional problems such as anxiety and/or

depression and those who engage in acting out or delinquent behaviors (e.g., Bernstein & Garfinkel, 1986; Kearney & Silverman, 1996; Last & Strauss, 1990).

Conversely, some students included in studies of school refusers exhibit comorbid anxiety and oppositional defiant disorder (Kearney & Silverman, 1996; King et al., 1998; Last et al., 1998). For example, Kearney (as cited in Kearney and Silverman, 1996) reported that of a sample of 64 school refusers, 6.3% had a diagnosis of oppositional defiant disorder that was comorbid with an anxiety disorder.

TRUANCY AND SCHOOL DROPOUT

Voluminous research has been conducted on the broad topics of truancy and its link to school dropout. A commonly cited theme in the literature indicates that students who drop out of school feel alienated from peers and teachers. Finn (1989) identified a lack of participation in school activities and identification with school as contributing to truancy and later dropout. Another contributing variable is the complaint that teacher expectations are too low for children who have been identified as high risk (Kagan, 1990).

Truancy and school dropout have been associated with high rates of retention in earlier grades (Kortering, Hess, & Braziel, 1997). For some students, years of difficulty with schoolwork lead to a sense of discouragement. Much of the time, disengagement from school can be traced back to elementary school, leading Finn (1989) to describe dropout as a process rather than a discreet decision. Accordingly, Doll and Hess (2001) call for educators to address the “emerging disengagement from schooling evidenced among some elementary school students” early on rather than waiting to intervene in high school (p. 353).

A more thorough discussion of risk and resiliency factors associated with truancy and school dropout is beyond the scope of this book. The reader is referred to Gutkin (2001) and Kortering et al. (1997) for in-depth examination of the topic.

Given the legal requirements under compulsory school attendance laws, some children with emotionally based school refusal are referred to the courts for truancy by school officials. For example, Bernstein and Garfinkel (1986) studied 26 chronic school refusers, ages 9–17 years, and found that 21 met criteria for either an anxiety or affective disorder or both. Of the 26 children included in the study, 42% had been charged with truancy. Bernstein and Garfinkel observed that pressure resulting from court referral was often helpful in getting the child in for evaluation.

A FUNCTIONAL APPROACH TO CLASSIFICATION

Much of the most recent literature published on classification of school refusal behavior is in the area of functional approaches (e.g., Evans, 2000; Kearney, 2001). Functional subtypes of school refusal behavior are based on factors that motivate the child to want to stay home. Of primary importance is an analysis of the cause or function of the child's behavior. One such functional conceptualization, proposed by Kearney and Silverman (1990, 1996, 1999), outlines four subtypes of school refusal behavior. The four subtypes are based on motivating variables for the school refusal behavior and are further defined by whether the behavior is reinforced through negative reinforcement (the behaviors are reinforced by avoidance of unpleasant situations) or positive reinforcement (the behaviors are positively reinforced outside of the school setting through gaining attention or rewards).

The first group, *children who refuse school in order to avoid stimuli that result in negative affectivity*, are those who traditionally fall under the school phobia, separation anxiety construct and includes children who refuse school because of fear, anxiety, depression, and/or somatic complaints. The function or cause of the school refusal behavior is the child's desire to avoid anxiety-producing situations such as being separated from a loved one. The behavior of staying home is negatively reinforced through a pattern of avoidance of aversive feelings and cognitions.

The second group, *children who avoid school to escape social and/or evaluative situations at school*, are children who are socially anxious. As with the first group, the child seeks to avoid or escape fear- or anxiety-provoking situations. The function or cause of the school refusal behavior is the child's desire to escape social or performance situations that cause extreme anxiety (giving a speech, taking a test, socializing with peers).

The third group, *children who primarily avoid school to gain attention*, seek positive reinforcement from family members or others in their environment. These children may have separation anxiety that is exaggerated to gain attention. They can be manipulative, defiant, and engage in acting out behaviors (tantrums, screaming, running away). These children are generally younger in age.

The fourth group, *children who refuse school to seek tangible reinforcement outside of school*, are those children who skip school to engage in activities they consider more reinforcing such as watching television, sleeping, playing video games, or engaging in illegal activities such as drug use (Kearney, 2001). Kearney points out that although these youngsters typically do not exhibit emotional problems like anxiety or depression, negative affectivity may develop after they have been absent from school for a time. These children tend to be older and demonstrate higher rates of externalizing behaviors.

Some overlap among the subtypes is expected (Kearney, 1993). A child who initially stayed home to watch television or play video games may develop anxiety about going back to school to face peers and teachers. A child who stayed home because of separation anxiety may gain positive reinforcement at home by being allowed to play and gain attention from parents.

Kearney and Albano (in press) studied a sample of 143 children to determine diagnoses associated with each of the four functional categories. The children, ages 5–17 years, presented with general school refusal behavior (not solely anxiety-based) at two clinics specializing in the assessment and treatment of school refusal behavior. Results were that anxiety disorders were generally more closely associated with negatively reinforced school refusal behavior (children who avoid school due to anxiety or depression and those who wish to escape aversive social or evaluative situations). Separation anxiety was associated with the functional category of attention-seeking behavior. Oppositional defiant and conduct disorders were linked to the functional category of children who desire to pursue tangible reinforcement outside of school.

Reliability of clinician judgments regarding the function of children's school refusal behaviors was studied by Daleiden, Chorpita, Kollins, and Drabman (1999) using several judges who reviewed school refusal cases. The judges reviewed multiple sources of data on 20 children diagnosed with school refusal. Two factors, years of clinical experience and training in the four function model, were found to be related to the judge's ability to reliably determine whether the school refusal behavior was maintained by positive or negative reinforcement. The study underscored the need for practitioner training when using a functional model applied to school refusal behavior.

A CATEGORICAL PERSPECTIVE

The classification system outlined in the Diagnostic and Statistical Manual of Mental Disorders (4th ed.) (DSM-IV) (American Psychiatric Association, 1994) is a categorical approach based on specific criteria that describe features associated with adult and childhood psychopathology. The DSM-IV does not make a distinction between child and adult anxiety disorders. Separation anxiety disorder (SAD) is the only anxiety disorder designated as first diagnosed in childhood and adolescence. Reluctance or refusal to go to school is included in the diagnostic criteria for SAD.

Like adults, children and adolescents can be diagnosed under the anxiety disorders of panic disorder with or without agoraphobia, specific phobia, social phobia/social anxiety disorder, obsessive-compulsive disorder, post-traumatic stress disorder, and generalized anxiety disorder. Similarly, if criteria are met, children and adolescents can be diagnosed

with a mood disorder such as major depressive episode or dysthymic disorder. Developmental factors relative to children are to be considered within each diagnostic category.

Children can be diagnosed with the disruptive behavior disorders of oppositional defiant disorder (ODD) and conduct disorder (CD). ODD and CD refer to children who act out and have behavioral problems. The DSM-IV defines the essential feature of ODD as “a recurrent pattern of negativistic, defiant, disobedient, and hostile behavior toward authority figures that persists for at least 6 months” (American Psychiatric Association, 1994, p. 91). The essential feature of conduct disorder is defined as “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated” (p. 85). Truancy is one of the diagnostic criteria found under conduct disorder.

Studies that have explored diagnostic subgroups associated with school refusal behavior have found anxiety disorders to be most prevalent (Bernstein et al., 1997; Kearney & Albano, in press; Last et al., 1987; Last & Strauss, 1990). Kearney and Albano examined a group of 143 children demonstrating school refusal behavior and found SAD to be most prevalent (22.4%), followed by generalized anxiety disorder (10.5%) and oppositional defiant disorder (8.4%). Other diagnoses included major depression (4.9%), specific phobia (4.2%), and social anxiety disorder (3.5%). There was considerable comorbidity with several of the subjects receiving more than one diagnosis.

Last and Strauss (1990) analyzed a group of 63 school refusing children and adolescents referred to an anxiety disorder clinic and found the following anxiety disorder diagnoses: SAD (38.1%), social phobia (30.2%), simple phobia (22.2%), panic disorder (6.3%), and post-traumatic stress disorder (3.2%). One-quarter of the 63 children were diagnosed with comorbid overanxious disorder.

Similarly, in a sample of 64 children with school refusal behavior, Kearney (as cited in Kearney & Silverman, 1996) reported that the most frequent diagnoses were overanxious disorder (18.8%), SAD (18.8%), and avoidant disorder (7.8%). As is typical for children with school refusal, there was considerable comorbidity between anxiety disorders in this group. For example, for children diagnosed with SAD, 66.7% also met criteria for overanxious disorder. Major depression was present in 6.3% of this group of children. As was previously noted, ODD was present in 6.3% of the sample. An important finding with regard to this sample of children was that 26.6% of the children did not meet criteria for diagnosis of any disorder.

Other studies have reported similar findings. For example, Kearney and Albano (in press) found that 32.9% of their sample of 143 children received no diagnosis. Bernstein

and Garfinkel (1986) found that 11.5% of their sample did not meet diagnostic criteria for any disorder. Kearney (2001) observed that children who do not meet diagnostic criteria for any mental disorder may have exhibited symptoms of various disorders associated with school refusal (e.g., anxiety, depression) that were not at clinical levels. King et al. (1995) assert that for children who do not present with a diagnosable disorder, the problem may be less child-related and more likely related to parental psychopathology or to a “systemic problem in the school itself” (p. 15).

Though prevalence rate estimates vary, several studies have revealed a link between school refusal and depression (Bernstein & Garfinkel, 1986, 1988; Last et al., 1987; Last & Strauss, 1990). Based on a review of seven studies examining diagnoses associated with school refusal, Kearney (1993) reported an estimated depression and school refusal comorbidity rate of 31.4%. In their study of 26 early adolescents with chronic school refusal, Bernstein and Garfinkel (1986) reported a strong overlap between the presence of anxiety disorders and depression. Sixty-nine percent of the adolescents met criteria for an affective disorder (major depressive episode or adjustment disorder with depressed mood). Of those individuals diagnosed with depression, 50% met criteria for both an anxiety disorder and depression. The students who scored the highest on self-report measures for anxiety and depression were considered to have more severe symptoms than those diagnosed with anxiety alone. However, the group who met criteria solely for a mood disorder did not differ in severity from the combined anxiety and depression group. Examples of severe symptoms included suicidal ideation, panic attacks, and symptoms of agoraphobia.

Due to evidence linking depression and school refusal, the possibility of the presence of depression or symptoms/characteristics of depression should not be overlooked. Primary features of depression in school-aged children are well documented: depressed mood or marked sadness, lack of interest in activities, failure to make expected weight gains, sleep difficulties, fatigue or lethargy, feelings of worthlessness/inadequacy or excessive guilt, difficulty concentrating or indecisiveness, and thoughts of death or suicidal ideation (American Psychiatric Association, 1994).

Anger, irritability, and somatic complaints are common characteristics of depression manifested in children and adolescents. Negative affectivity is prevalent and easily identified. Comments such as “School is dumb,” “I hate it,” and “Nobody likes me” point to an underlying negative affectivity from students who simply look sad. A most serious symptom of depression among children and adolescents is preoccupation with suicide. The presence of suicidal thoughts or plan should be considered significant and appropriate steps taken to ensure the safety of the child (see Poland & Lieberman, 2002, for a detailed discussion of best practices in suicide intervention).

PRESENTING FEATURES OF STUDENTS WITH ANXIETY-BASED SCHOOL REFUSAL

The following section describes the essential features of separation anxiety, social phobia, and generalized anxiety disorder, all found in high rates in studies of children who exhibit school refusal. Though they are presented as distinct clusters with emotional, cognitive, and behavioral features, it is often difficult to distinguish between anxiety disorders because there is so much overlap among them.

SEPARATION ANXIETY

Children with separation anxiety show excessive fear surrounding separation from major attachment figures (American Psychiatric Association, 1994; see Table 2 on page 14). They become preoccupied with thoughts of harm befalling their loved ones. These children worry about their parents getting hurt in an automobile accident, getting sick, or dying. The separation anxiety is extreme and falls outside of the boundaries of what would be considered “normal” separation reluctance found in many young children.

At home children with SAD are overly dependent, often resisting sleeping or even playing alone. In school, difficulty concentrating on school work is common, and children may frequently request to call or go home. As shown in Table 2, reluctance or refusal to go to school is one criterion for diagnosis under SAD. Close inspection of attendance records may reveal a pattern of tardiness possibly the result of before-school battles with parents. Panic-like symptoms may result in clinging or even striking out at others trying to pry a child away from a caregiver. Physical complaints are common and include stomachaches, headaches, and nausea or vomiting (American Psychiatric Association, 1994).

SOCIAL PHOBIA/PERFORMANCE ANXIETY

Children with social phobia have extreme fear surrounding social situations where the possibility of embarrassment may occur (see Table 3 on page 16). Social or performance situations create intense anxiety and avoidance responses although the situation may be “endured with dread” (American Psychiatric Association, 1994, p. 411). Public speaking, tests, or anticipating having to socialize at recess time are examples of situations that cause extreme anxiety for children with social or performance anxiety. Worrying about what others think, concern over how they will be judged, and fear of humiliation are cognitive features associated with social anxiety. An assignment to give a speech can result in severe anticipatory anxiety for students who self-consciously fear others will see their hand tremble or hear their voice shake. Social anxiety can manifest itself as dread and avoidance of the school locker room or refusal to participate in sports because of a fear of humiliation. The resulting restriction and avoidance of activities and peers causes many of

TABLE 2

DIAGNOSTIC CRITERIA FOR SEPARATION ANXIETY DISORDER

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- A. Developmentally inappropriate and excessive anxiety concerning separation from home or from those to whom the individual is attached, as evidenced by three (or more) of the following:
1. recurrent excessive distress when separation from home or major attachment figures occurs or is anticipated
 2. persistent and excessive worry about losing, or about possible harm befalling, major attachment figures
 3. persistent and excessive worry that an untoward event will lead to separation from a major attachment figure (e.g., getting lost or being kidnapped)
 4. persistent reluctance or refusal to go to school or elsewhere because of fear of separation
 5. persistently and excessively fearful or reluctant to be alone or without major attachment figures at home or without significant adults in other settings
 6. persistent reluctance or refusal to go to sleep without being near a major attachment figure or to sleep away from home
 7. repeated nightmares involving the theme of separation
 8. repeated complaints of physical symptoms (such as headaches, stomachaches, nausea, or vomiting) when separation from major attachment figures occurs or is anticipated
- B. The duration of the disturbance is at least 4 weeks.
- C. The onset is before age 18 years.
- D. The disturbance causes clinically significant distress or impairment in social, academic (occupational), or other important areas of functioning.
- E. The disturbance does not occur exclusively during the course of a Pervasive Developmental Disorder, Schizophrenia, or other Psychotic Disorder and, in adolescents and adults, is not better accounted for by Panic Disorder With Agoraphobia.
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these children to be lonely and to have few friends (Beidel, Turner, & Morris, 1999). Like separation anxiety, severe social or performance anxiety may result in panic-like symptoms or panic attacks (American Psychiatric Association, 1994).

Kearney and Beasley (1994) surveyed 63 professional psychologists in children and family practice. The psychologists reported that half of the children they treated for school refusal stayed home in order to avoid aversive social situations such as tests, giving speeches, the curriculum and homework, interacting socially with others, and athletic performance.

GENERALIZED ANXIETY DISORDER

For children diagnosed with generalized anxiety disorder, worry and anxiety are excessive, difficult to control, and significant enough to interfere with school performance (American Psychiatric Association, 1994) (see Table 4 on page 17). For these children, the world is perceived as threatening. There may be a vague sense that something bad is going to happen or worries about specific events such as tornadoes or war. Perfectionism is a characteristic of children with generalized anxiety disorder. They may frequently re-do assignments, starting over so many times that homework time becomes excruciating for both child and parent. Because of a sense of inadequacy and uncertainty, children with generalized anxiety disorder seek frequent reassurance from parents, teachers, and other adults regarding their performance. They are often concerned about pleasing others and may tend to try to hide their distress from teachers and peers (Kendall, Chansky, et al., 1992). Additional features include fatigue, restlessness, difficulty concentrating, irritability, sleep disturbance, and muscle tension (American Psychiatric Association, 1994).

SOMATIC COMPLAINTS AND SCHOOL REFUSAL BEHAVIOR

Children presenting with school refusal behavior have high rates of somatic complaints. As was previously noted, in a survey of 288 elementary and secondary school principals, Stickney and Miltenberger (1998) found an overall rate of 2.3% of students identified as school refusers. Somatic complaints without the presence of a medical condition were reported present in 49% of the school refusers with 30% demonstrating somatic complaints with an accompanying medical condition.

It can be difficult to determine when children who refuse school are truly sick. Teachers and school nurses, however, become adept at knowing who is a “regular,” that is, a student who visits the nurse’s office on a regular basis with physical complaints (headaches, stomachaches, or a hurt finger). A more complicated scenario occurs when a student’s legitimate medical concern (e.g., asthma) contributes to a pattern of school refusal. Here, a

TABLE 3

DIAGNOSTIC CRITERIA FOR SOCIAL PHOBIA

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- A. A marked and persistent fear of one or more social or performance situations in which the person is exposed to unfamiliar people or to possible scrutiny by others. The individual fears that he or she will act in a way (or show anxiety symptoms) that will be humiliating or embarrassing. Note: In children, there must be evidence of the capacity for age-appropriate social relationships with familiar people and the anxiety must occur in peer settings, not just in interactions with adults.
- B. Exposure to the feared social situation almost invariably provokes anxiety, which may take the form of a situationally bound or situationally predisposed Panic Attack. Note: In children, the anxiety may be expressed by crying, tantrums, freezing, or shrinking from social situations with unfamiliar people.
- C. The person recognizes that the fear is excessive or unreasonable. Note: In children, this feature may be absent.
- D. The feared social or performance situations are avoided or else are endured with intense anxiety or distress.
- E. The avoidance, anxious anticipation, or distress in the feared social or performance situation(s) interferes significantly with the person's normal routine, occupational (academic) functioning, or social activities or relationships, or there is marked distress about having the phobia.
- F. In individuals under age 18 years, the duration is a least 6 months.
- G. The fear or avoidance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition and is not better accounted for by another mental disorder (e.g., Panic Disorder With or Without Agoraphobia, Separation Anxiety Disorder, Body Dysmorphic Disorder, a Pervasive Developmental Disorder, or Schizoid Personality Disorder).
- H. If a general medical condition or another mental disorder is present, the fear in Criterion A is unrelated to it, e.g., the fear is not of Stuttering, trembling in Parkinson's disease, or exhibiting abnormal eating behavior in Anorexia Nervosa or Bulimia Nervosa.
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TABLE 4

DIAGNOSTIC CRITERIA FOR GENERALIZED ANXIETY DISORDER

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- A. Excessive anxiety and worry (apprehensive expectation), occurring more days than not for at least 6 months, about a number of events or activities (such as work or school performance).
- B. The person finds it difficult to control the worry.
- C. The anxiety and worry are associated with three (or more) of the following six symptoms (with at least some symptoms present for more days than not for the past 6 months). Note: Only one item is required in children.
1. restlessness or feeling keyed up or on edge
 2. being easily fatigued
 3. difficulty concentrating or mind going blank
 4. irritability
 5. muscle tension
 6. sleep disturbance (difficulty falling or staying asleep, or restless unsatisfying sleep)
- D. The focus of the anxiety and worry is not confined to features of an Axis I disorder, e.g., the anxiety or worry is not about having a Panic Attack (as in Panic Disorder), being embarrassed in public (as in Social Phobia), being contaminated (as in Obsessive-Compulsive Disorder), being away from home or close relatives (as in Separation Anxiety Disorder), gaining weight (as in Anorexia Nervosa), having multiple physical complaints (as in Somatization Disorder), or having a serious illness (as in Hypochondriasis), and the anxiety and worry do not occur exclusively during Posttraumatic Stress Disorder.
- E. The anxiety, worry, or physical symptoms cause clinically significant distress or impairment in social, occupational, or other important areas of functioning.
- F. The disturbance is not due to the direct physiological effects of a substance (e.g., a drug of abuse, a medication) or a general medical condition (e.g., hyperthyroidism) and does not occur exclusively during a Mood Disorder, a Psychotic Disorder, or a Pervasive Developmental Disorder.
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child's asthma may be an initial legitimate reason for school absence. Later, anxiety about returning to school serves to maintain the school avoidance even after the child recovers physically. School personnel should consult with the child's physician to determine if a medical condition such as asthma would preclude return to school (King et al., 1995) or result in restrictions on activity while in school.

Certainly, there are times when a child clearly has a legitimate medical concern that necessitates extended absence from school. A child's absenteeism as a result of a legitimate medical illness is not considered school refusal.

A DIMENSIONAL PERSPECTIVE: INTERNALIZING VERSUS EXTERNALIZING BEHAVIORS

Empirically based classification systems use factor analysis to identify clusters of emotional or behavioral characteristics in children and adolescents. A widely used empirically based classification system is the Achenbach System of Empirically Based Assessment (Achenbach, 1991a, 1991b; Achenbach & Rescorla, 2001). Two components of the system, the Child Behavior Checklist (CBCL) and the Teacher Report Form (TRF), are behavior rating scales used to obtain parent and teacher perspectives of a child's behavior.

The internalizing and externalizing scales of the CBCL and TRF reflect a distinction between fearful, over-controlled, inhibited behavior, and aggressive, antisocial, under-controlled behavior. The scales are further broken down into the following eight syndromes: Anxious/Depressed, Withdrawn/Depressed, Somatic Complaints, Social Problems, Thought Problems, Attention Problems, Rule-Breaking Behavior, and Aggressive Behavior.

The internalizing grouping of the newly revised CBCL (Achenbach & Rescorla, 2001) is composed of three of the syndromes, Anxious/Depressed, Withdrawn/Depressed, and Somatic Complaints. Internalizing behavior refers to anxiety, depression, somatic complaints, and withdrawal. Two scales, Rule-Breaking Behavior and Aggressive Behavior, comprise the externalizing grouping that refer to acting out behavior manifested as conflicts with other people (Achenbach & Rescorla, 2001).

Although there is not a school refusal syndrome as such, the item "fears going to school" is included under the Anxious/Depressed syndrome on the internalizing dimension. The item, "truancy, skips school" falls under the Rule-Breaking Behavior syndrome on the externalizing dimension. Though there are children who have primarily internalizing or, conversely, primarily externalizing problems, the dimensions are not mutually exclusive especially for children with significant pathology (Achenbach & Rescorla, 2001). Children

who have significantly high scores on one dimension tend to score at least above average on the other (Achenbach, 1991a; Achenbach & Rescorla, 2001).

Likewise, analysis of the CBCL and TRF by researchers interested in school refusal behavior has revealed that the scales may not discriminate among subtypes of school refusers because of the extreme diversity among them (Kearney & Silverman, 1996). Nonetheless, when implemented as part of a multidimensional assessment, analysis of the constructs of internalizing and externalizing behavior can be useful in diagnostic decision making and intervention planning for children with school refusal behaviors.

SUMMARY

There is no single cause for school refusal. Children who exhibit school refusal are a heterogeneous group who differ in level of severity and motivation for their behavior. Among children who refuse school for emotional reasons, anxiety disorders are most prevalent. School refusal is prevalent in approximately 2% of school-age children though some estimates are as high as 5%.

The number of terms applied to school refusal and associated constructs is confusing for those seeking to understand and intervene effectively. School refusal refers to primarily emotionally based absenteeism initiated by the child and includes children who exhibit anxiety disorders such as separation anxiety, social phobia, as well as co-occurring depression. The term, “school refusal behavior,” encompasses both emotionally driven school refusal and the behaviors associated with truancy.

Classification systems have typically assigned subtypes using functional, categorical, and dimensional perspectives. A functional approach toward classification identifies motivating variables for the school refusal behavior. Most school psychologists are well versed in the use of functional behavioral assessment. Therefore, applying a functional approach toward understanding school refusal behavior would appear to be particularly applicable for those working in school settings.