School Refusal Behavior

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School refusal behavior

- Child-motivated refusal to attend school or difficulty remaining in classes for an entire day
- Continuum of school attendance: complete absence, periodic absences, tardiness, morning misbehaviors to avoid school, and school attendance under duress
- Each point on the continuum may be described as acute or chronic

Functions of school refusal behavior

- Avoidance of school-related stimuli that provoke a general sense of anxiety and depression
- Escape from aversive social and/or evaluative situations
- Pursuit of attention from significant others
- Pursuit of tangible rewards outside of school

Contextual factors - child

- Extensive work hours outside of school
- Child psychopathology
- Grade retention/poor school commitment
- Poor health or academic proficiency
- Pregnancy
- Problematic relationships with authority figures/history of absenteeism
- Maltreatment or other trauma
- Underdeveloped social/academic skills

Contextual factors - parent

- Problematic parenting skills or styles
- Low expectations of school attendance
- Poor communication with school officials
- Poor involvement and supervision
- Psychopathology
- School dropout among relatives
- School withdrawal
- Single parent

Contextual factors - family

- Enmeshment/intense conflict or chaos
- Poor cohesion and expressiveness
- Homelessness/poverty
- Large family size
- Poor access to educational aids
- Resistance to acculturation/ethnic differences from school personnel
- Stressful family transitions
- Transportation problems

Contextual factors - peers

- Participation in gang-related activity
- Poor participation in extracurricular activities
- Pressure to conform to group demands for absenteeism or other delinquent acts
- Proximity to deviant peers
- Support for alluring activities outside of school such as drug use
- Victimization from bullies or otherwise

Contextual factors - school

- Dangerousness/poor school climate
- Frequent teacher absences
- High systemic levels of grade retention
- Highly punitive or legal means to address all cases of problematic absenteeism
- Inadequate, irrelevant, or tedious curricula
- Inadequate praise for student achievement and attendance
- Inadequate responsiveness to diversity issues
- Poor monitoring of, or consequences for, absenteeism
- Poor student-teacher relationships

Contextual factors - community

- Disorganized/unsafe neighborhood
- Economic pull factors such as plentiful, well-paying jobs requiring little formal education
- Geographical cultural and subcultural values
- High gang-related activity
- Interracial tension
- Lack of social and educational support services
- School district policies and legal statutes regarding absenteeism

Treatment for function one

- Breathing retraining
- Relaxation training/tension-release model
- Hypnosis or meditation
- Pharmacotherapy (tricyclic antidepressants (imipramine), SSRIs, benzodiazepines, buspirone, beta-blockers (propranolol), antiepileptics (gabapentin)

Treatment for function one

- Gradual exposure to school setting
  - Morning
  - Afternoon
  - Lunch
  - Favorite time of day
  - Attending school but outside the classroom

Treatment for function two

Overall models:

- FEAR model: Feeling frightened? Expecting bad things to happen? Attitudes and actions that will help? Results and rewards?
- STOP model: Are you feeling scared? What are you thinking? Other helpful thoughts? Praise yourself for using these steps, and plan for next time

Cognitive treatment procedures

Major cognitive therapy techniques:

- "What is the evidence?"
- "What if?"
- Examining the alternatives
- Decentering
- Hypothesis testing
- Soften all-or-none language

Common exposures for function one and two

Riding alone on a school bus, entering a classroom by oneself, being in class without one's parents, being in school without calling parents, transitions between classes, unpredictable circumstances, speaking before others, starting or maintaining conversations, going to gym class, eating with friends, asking or answering a question in class, taking tests, walking in hallways at school, performing before others

Treatment for function three

- Restructuring parent commands
- Ignoring simple inappropriate behaviors
- Establishing fixed routines
- Setting up rewards and punishments
- Forced school attendance
- Excessive reassurance-seeking

Treatment for function four

- Contingency contracting
- Escorting youth to school and classes
- Communication skills training
- Peer refusal skills training
- Increased supervision of the child

Systemic prevention

- Restructuring the homeroom teacher's role
- Peers as monitoring/reinforcing agents
- Maintain a student's peer group in classes
- Encourage communication between teachers and parents
- School-based rewards for attendance
- School-based punishments for absences
- Parent and child support groups
- Educate fellow professionals about SRB
- Teacher support and stress reduction

Systemic intervention

- Summer bridge/transitional programs
- Conflict resolution
- Increase parent-school official cooperation
- Customizing curricula
- Using mentors
- Early education, family, health services
- Court referral and community services
- Police pick-up and return to school
- Triage model

Case #1

Colby is a 14-year-old boy in ninth grade who has missed 13 days of school this semester. He has a history of school refusal behavior dating to the start of middle school. Colby misses school for tangible rewards outside of school, including time spent with friends, as well as to avoid some distress at school. Colby's parents blame school officials for their son's absenteeism and for failing to inform them of the severity of their son's problem. The parents do not return phone calls about their son's situation or show for scheduled appointments with the school counselor.

Case #2

Sarah is an 11-year-old girl in sixth grade with severe anxiety about attending school and interacting with peers. Her parents are fairly strict and require Sarah to come home right after school. She is not permitted to attend extracurricular activities and often seems socially withdrawn at school. Sarah's parents have been reluctant to discuss their daughter's "problem" and have implied that the school is to blame. They are considering home schooling as an option because their daughter seems so distressed, especially on Sunday evenings prior to a school week.

Case #3

Dylan is a 15-year-old boy in tenth grade who reports severe sadness and some suicidal ideation when attending school. His symptoms also include lethargy, sleep disturbance at night, and somatic complaints such as stomachaches. Dylan goes to school for about 5 periods per day, though this is sporadic. He is on antidepressants but his symptoms remain unstable. Dylan's mother also has depression and does not require her son to attend school. Dylan's father tries to get his son to go to school but is afraid of triggering suicidal ideation should he push too hard.

Case #4

Shena is a 16-year-old girl who attended school with moderate success until her pregnancy began 4 months ago. Since that time, Shena has missed about a third of days of school and has said she wishes to drop out. She has no plans to pursue an equivalency diploma at this time. Shena's parents can offer some support but are not particularly enthusiastic about encouraging Shena to remain in school. Shena's school counselor has encouraged her to remain in school, but Shena says school is boring and she would rather attend doctor and other appointments regarding her unborn child.

Case #5

Justin is a 17-year-old boy who has had moderate but not outstanding attendance and success in school during his education. Given the 2009 American economy, however, his parents have placed pressure on Justin to increase his work hours outside of school to support the family. Justin has a part-time job now but has the opportunity to accumulate more hours and potentially the prospect of a full-time position if he makes the commitment to do so. Doing so, however, will likely mean less time for school or even leaving school altogether.

Case #6

Jessica is a 7-year-old girl in second grade who does not speak to anyone at school. She is extremely shy and somewhat willful in her behavior, though she does associate herself with two other girls in her class who help her communicate with others. Attendance was not an issue in kindergarten or first grade, but Jessica has increasingly refused to attend school this year. She tells her parents that her teacher is making more demands on her to speak in class. The school counselor has told the family that Jessica's grades are declining because she is failing required verbal tasks.

Case #7

Matthew is a 12-year-old boy who recently began middle school and is having great difficulty adjusting to his new surroundings. Matthew was diagnosed with dyslexia in fourth grade and has struggled with reading, spelling, and math since kindergarten. He says he is frustrated with school and that he no longer wants to go. Matthew has missed several days of school this year because of "illness" and has skipped several classes that involve performance before others. His grades are poor and he sometimes lashes out at others in class.

Treatment options

A. Individualized education plan focusing on learning challenges, ongoing assessment of academic functioning, and management of aggression.
B. Referral to therapist who concentrates on cognitive-behavioral strategies to enhance relaxation and improve parental control.
C. Medical examination to explore biological problems that prevent school attendance as well as medication for anxiety-related issues.
D. Ongoing practice of social and academic skills, attendance monitoring, peer intervention, and modifying the role of the homeroom teacher.

Case #8

Jordan is an 11-year-old girl who presents with severe somatic complaints upon attending school. She says she has intense stomachaches and headaches in the morning before school. In addition, Jordan vomits on the way to school or has diarrhea in the morning that keeps her in the bathroom for extended periods of time. She is chronically tardy to school because of these symptoms and her grades are suffering. Jordan's parents say her physical symptoms dissipate on days she does not have to attend school, but that her symptoms are quite evident on school days.

Treatment options

A. Contingency contracts to provide greater incentives for attendance and disincentives for absences, peer-based intervention.
B. Relaxation training, morning contingency management plan, and improve parent-school official contact regarding attendance.
C. Medical examination to explore biological problems that prevent school attendance as well as medication for anxiety-related issues.
D. Exploration of alternative school placement to focus on part-time attendance with some home-based instruction.

Case #9

Gisela is a 13-year-old girl in eighth grade who has recently begun refusing school to hang out with her friends. Gisela displayed average grades in elementary school but her academic performance has slipped considerably in the last two years. Her parents speak only Spanish and rarely communicate with school officials. The parents have said in the past that they do not fully understand Gisela's homework or notes sent home by the teacher. They do not attend parent-teacher conferences and did not finish high school themselves.

Treatment options

A. Examination of alternative educational placements with focus on part-time attendance and more gradual credit accumulation.
B. Referral to Spanish-speaking therapist who concentrates on cognitive-behavioral and family strategies to enhance attendance.
C. Home visits, contingency contracting to increase incentives for attendance, and use of diverse faculty to increase communication with parents.
D. Increased attendance monitoring during high-risk flight times with systemic focus on returning truant youths to the school campus.

Case #10

Madison is a 12-year-old girl in seventh grade who was diagnosed three years ago with Asperger's syndrome. Madison does well academically in school but struggles mightily with associations with peers. She reports having been teased and bullied by others at school and tends to speak to few people. Her speech is marked by odd statements and she displays tic-like movements that bother others. Madison has begun asking her parents for home schooling and says she does not feel safe at school. This problem came to a head recently when Madison did not show up for school one day.

Treatment options

A. Individualized education plan focusing on learning challenges, ongoing assessment of academic functioning, and management of speech issues.
B. Social skills training, parent-based contingency management, and peer-based education about tics and peer-based intervention for attendance.
C. Examination and remediation of safety-related issues at school, including ongoing threats, as well as transitional education programs.
D. Modifying role of the homeroom teacher, referral to in-school health service, and utilizing the special education teacher as primary liaison.

Case #11

Jeff is a 10-year-old boy in fifth grade who has displayed intense social and generalized anxiety about attending school. He has missed the last four weeks of school. Jeff and his parents are currently seeing a therapist who has used cognitive, behavioral, and family techniques to reduce Jeff's anxiety and control some of his catastrophic thoughts about school. School officials, however, insist that Jeff must attend school full-time and will not accede to requests for an initial part-time schedule. Jeff is to be referred to a juvenile justice department.

Treatment options

A. Escorting Jeff to and from school and from one area of the school to another, parent-based contingency management, exploring medication.
B. Therapist-school official-parent meetings at school, remediation plan regarding make-up work, solicitation of input from justice officials.
C. Customizing Jeff's curriculum to meet his educational needs, revisiting system-wide policies regarding absenteeism, alternative placement.
D. Referral to juvenile justice system, consultation with parents about legal status, parent exploration of legal options.

Case #12

Carson is an 8-year-old boy in third grade who throws intense temper tantrums when at school in an effort to be sent home. Carson has some symptoms of ADHD, especially impulsive behavior, but his screaming and running about in class seem to have to do more with wanting to be sent home from school. Carson's parents are motivated to get their son to school, but have great difficulty getting him there in the morning. Carson is so disruptive at school that he is often sent to the nurse's or principal's office or simply sent home. His behavior has escalated in recent weeks.

Treatment options

A. School- and home-based consequences for disruptive behavior, increased supervision at school, curriculum modification.
B. Peer-based management of behavior and attendance, relaxation training, behavioral contracts to increase incentives for attendance.
C. Parent-school official work toward IEP for behavioral issues, exploration of comorbid medical issues, legal referral/intervention.
D. Modifying school climate, pursue self-contained educational unit/office, increase extracurricular activities to build social skills and friendships.