

## School Refusal

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Every child might not want to go to school at some point. The child may pretend to be ill, sleep in, or simply announce that she does not feel like going to school today. What do we do, though, when a day, a week, a month, or two go by, time passes, and the child continues to sit at home, firmly refusing to go to school?

The child may be developing a disorder known as school refusal. The cause might be social anxiety, fear of failing at school or of the teacher, or perhaps a behavioral problem, or a refusal to accept frameworks and authority. Whether the child is 6 or 16 and whether the cause is anxiety or rebellion, how do we solve the problem and bring the child back to an educational setting?

School refusal is a multi-age phenomenon which has been growing in recent years, to the point of reaching epidemic proportions. Parents who encounter school refusal do not know how to handle it, and their reactions range from pity, threats, promises, and enticements to helplessness and acceptance of the situation. Nor do schools have any real tools to bring the child back to school. In many cases, the entire system is helpless in the face of the child's persistent refusal to go to school.

In research literature, school refusal applies to children between the ages of 5 and 17 who display one or more of the following behaviors for at least two weeks: (1) are completely absent from school (complete absenteeism); (2) arrive at school but leave during the day (partial absenteeism, cutting class); (3) arrive at school, late or on time, after being very difficult throughout the morning (misbehaviors, tardiness); (4) arrive at school, late or on time, despite massive anxiety and recurring pleas not to go (duress).

Every school-refusal episode can include each of these behaviors, which can vary on a daily basis. If these symptoms last up to six months, we refer to the condition as acute school refusal. If they persist for more than six months, we refer to it as chronic school refusal.

Some ages or periods of childhood are more susceptible to school refusal than others: ages 5–6, when children enter preschool or elementary school; ages 12–13, due to the pressures involved with entering junior high school or middle school; and ages 16–17. In addition, after a long absence such as holiday or family vacation, children may refuse to go back to school or have a hard time readjusting to their normal routine.

Accurately identifying the prevalence of school refusal is difficult. When looking at only complete absenteeism, the prevalence rate can range from 5 percent to 7.9 percent. When looking at the entire school-refusal spectrum (partial absenteeism, misbehaviors, duress, and tardiness), though, rates can rise to as high as 28 percent. The prevalence does not vary due to sex or IQ. School refusal is the most prevalent of childhood disorders and is, therefore, a serious mental and physical health concern.

School refusal is known to have high co-morbidity rates with other disorders, for example: depression, 13.9%; general anxiety (GAD) and separation anxiety (SAD), 10.8%; conduct disorder, 5%; and oppositional defiant disorder, 5.6%.

In general, children gradually display school-refusal symptoms. The internalizing symptoms include general or social anxiety, fear, depression, and psychosomatic complaints, such as headaches and stomach aches. The externalizing symptoms include running away from home or school, physical or verbal aggression, tantrums, and hanging on to the parent and refusing to move (Kearney et al., 2007).

Clinical experience and research literature show that children who refuse to go to school fall into two main groups: (1) children with school anxiety whose main characteristic is fright and (2) children with behavioral problems whose main difficulty is accepting authority and boundaries. Children may experience school anxiety because of a fear of failure, social anxiety, separation anxiety, or fear of leaving their home for an environment they perceive as unsafe. These children generally prefer to close themselves up at home and keep their anxiety a secret, even at the cost of severing social contacts. Children with behavioral problems who do not accept authority and boundaries tend to roam the streets in search of attractive stimuli instead of going to school. They do not feel discomfort with their choice to eschew learning and replace their old friends with street children. There are also children who fit into both categories.

Not only do the school-refusal motivations and behaviors differ between these two groups, but also the undesirable consequences. Children in the first group are at a higher risk of increasing withdrawal, dissociation, and social avoidance, damaging their ability to maintain a social life and function in the outside world. Children in the second group are subject to an increased risk of bad influences, exposure to drugs and alcohol, and the development of behavior patterns associated with street life, such as delinquency and sexual promiscuity. Both groups have a higher risk of developing depression. In the long term, school refusal is associated with difficulties in maintaining a job, marital and family problems, social seclusion, drug and alcohol abuse, and criminal behaviors.

### **The Child's Identity as a Student**

The first and immediate damage caused to a child who drops out of school is inflicted on his identity as a student. A central part of his overall identity, a child's identity as a student is tied not only to his studies, but also to the reality that the child spends a significant part of the day at school, has occupations and obligations connected to the school, is connected with other students, and has his calendar tightly connected with the school year. A child who stops going to school develops a large gap in his identity and his life. Gradually, such a child will develop a new internal discourse in which she will tell herself, "I can't stand being at school!" "I'm out of the children's group!" "I can't meet the requirements!" The reflections the child receives from others also change. The labels of "weird kid," "reclusive kid," and "kid who can't cope" gradually stick to him, and the decline of his social contacts will more deeply imprint these labels on him. Thus, a new identity of a dysfunctional, avoidant, socially dissociated, and incapable child takes shape. The longer the absence from school, the more deeply the negative self-image takes root. Over time, depression symptoms may develop.

The parents' position is not easy, because they do not have an immediate solution to the child's anxiety disorder. Most parents try to persuade their child to return to school. When attempts at persuasion fail, parents tend to react in one of two ways: a display of anger, issuing blunt demands, or making horrible predictions about the unfortunate future awaiting the child if she does not go to school; or, in contrast,

reacting in deep sympathy with the child's distress and anxieties while surrendering to his pleas and leaving her at home as he wishes. Most parents range helplessly between these two extremes: anger and coercion on one hand, compassion and surrender on the other.

The non-violent resistance (NVR) method, though, offers parents an alternative approach that does not surrender to the child's wishes and does not escalate the situation but supports a persistent, non-violent effort to return the child to school. This treatment program is multi-systemic and includes the children, the school, and supporters. In addition, it does not rule out treatment for the child.

### **NVR Treatment for School Refusal Syndrome**

The treatment model uses the NVR approach combined with techniques from cognitive behavioral therapy models. The multi-systemic treatment program involves the parents and the school working closely together to restore the child's identity as a student. The assumption is that, when the child sees himself as a student again, he will go back to school.

The treatment consists of the following actions:

1. Consistently a clear message to the child about the need for him to go to school.

In conveying this message, parents begin to rebuild the child's identity as a student. Thus, for instance, even if the child still isn't going to school, she is required to prepare her school bag in the evening, get up in time in the morning, do homework, and go to sleep at a time that will enable her to wake up fresh in the morning. In this manner, the parents return the child's schedule to one appropriate for a regular student. Parents resist patterns which turn night into day and restore contact between the child and her teachers and group of peers. Thus, the reconstruction of her identity as a student begins even before she returns to school.

2. Parents announce that they will not cooperate with the child's refusal any more.

The announcement is meant to make it clear to the child that his parents are no longer willing to cooperate with school refusal even as they recognize his difficulties. The announcement is crafted so that it firmly states the parent's decision but doesn't devalue the child's difficulties. For example, parents could write a letter, saying:

"Dear Sarah,

We, Mom and Dad, have decided not to cooperate any longer with your refusal to go to school. Being a student is your main role at this stage of your life. We will not give in to outbursts or anxieties anymore. We will do everything we can in order to get you back to school, including asking for help from family, friends, and the school staff. We act out of love and care for you, and we realize that your anxiety is not easy to handle. We think it might be good for you to start treatment that will give you tools to deal with the anxiety, but we will not wait for that. This announcement is not a threat but an example of our duty as your parents."

3. Take steps to restore the child's identity as a student, and facilitate a gradual return to school.

A significant step in maintaining and restoring a child's student identity is to bring school boundaries into the

home. As mentioned earlier, it is important to insist that the child wake up every morning, arrange her school bag, and dress for school, even though she is not physically present at school. These actions are significant; even though the child is not going to school, they create a framework in which the child is viewed as a student and help preserve her identity as a student. Therefore, it is important not to allow a child who has stayed at home to watch television or play on the computer during school hours. Beyond not making the child's stay at home pleasurable, this measure tells the child that, until one o'clock (or whatever time until which she is supposed to be in school), she is treated as a student. At the time that school normally ends, the child may resume whatever regular activity in which she is interested. Other vital components of a child's identity as a student include doing homework, preparing for exams, and making up studies missed due to absence. Should the child refuse to cooperate with these processes, parents may use additional tools for constructive struggles, such as sit-ins and employing supporters.

The next step is planning and implementing a graduated return to school. This step is most relevant for children with anxiety but is helpful for others as well. For the anxious child, a graduated return to school starts with going for one hour for a few days, then going for two hours, and so on, according to the child's rate of progress.

#### 4. Involve the school in the treatment program.

The school should be informed as early as possible why a child is not going to class. Many times, parents play along with a child's request to hide the reason for his absence and provide him with excuses for truancy. By doing so, parents trap themselves in a web of cover-ups and lies to not only the teacher but also their extended family, the child's friends, and their parents. This array of lies perpetuates the problem and turns the parents into active participants in the child's absence from school. Parents must make a fundamental change and inform the school and those around them that the child suffers from anxiety (or behavioral issues) and is refusing to go to school. The parents should add, "We'll be glad to have you visit her at home and help her with the homework so she doesn't fall behind with school work and to support her in returning to school!" The parents should follow up this statement by coordinating with the school and other family members about how they are willing to assist the child and the parents.

The school should play a central role in bringing the child back to class. Therefore, the parents should make efforts to enlist the school in the treatment program to as great an extent as possible. A central goal is to secure the willingness of the homeroom teacher and the principal to call the child on the phone, visit her at home, personally receive the child at school, and provide support at the various stages.

#### 5. The school prepares for the student's return.

The school should act in a manner that conveys a clear message to the child that it is not giving up on her attendance and continues to view her as a student like any other child. School staff should contact the child and notify her that they are willing to help her solve the problem and ease her return to school and that they expect her to take part in all the duties and privileges of school activity. Thus, for example, all messages and memos regularly given to all students should continue to be sent to the child. The class which the child attends should also prepare to convey a similar message. For example, the child's regular

seat while at school should remain vacant, ready for the child's return to school. As well, the school could prepare a relaxation corner to which the child may go if she feels anxious.

6. The teacher should actively contact the child.

The homeroom teacher should contact the child. The teacher may call the child, see him at home, or invite him for a talk. The teacher will tell the child that she is aware of the reason for the child's absence and offer him help and support in solving the problem. The teacher's persistent presence, which rejects the child's attempts to sever the connection between them, is of great significance. In addition, it is useful to identify the person at the school who is closest to the child. This person can serve as a source of support at the school to whom the child can turn whenever he feels anxious.

7. Outside supporters facilitate the treatment program.

The role of supporters in cases of school refusal is to affirm the parental position, help with everyday practice, and witness the child's positive progress, among other acts.

8. Conciliatory acts create the appropriate environment.

To avoid a state in which struggles and conflicts constitute the central and sole axis around which contact with the child revolves, it is important to carry out conciliatory acts.

### **Child's Treatment**

If school refusal is rooted in anxiety, a child should receive individual treatment, such as anxiety-focused CBT, biofeedback, and medication. These recommended treatments can take place alongside parental efforts to return the child to school. Treatment of the child can focus on gradually exposing the sources of the anxiety and providing the child with tools to deal with school anxiety. It is important to remember that the child has the right to refuse treatment and that, while individual treatment can help solve the issue, it, by no means, is a condition for doing so.

A study conducted in Australia compared the efficacy of child CBT and parental training in treating school refusal. Both groups displayed vast improvement in school attendance and school refusal--related symptoms, but the parental training group had better outcomes in most parameters.

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