

What is wrong with Sandy????!!!! Is She Seriously Ill??? School Refusal; is it a Diagnosis or a Presenting Complaint???

Eman Ahmed Zaky*

Department of Pediatrics, Faculty of Medicine, Ain Shams University, Egypt

*Corresponding author: Eman Ahmed Zaky, Professor of Pediatrics and Head of Child Psychiatry Clinic, Department of Pediatrics, Faculty of Medicine, Ain Shams University, Egypt, Tel: 002-01062978734; E-mail: emanzaky@med.asu.edu.eg

Received date: Jan 11, 2017, Accepted date: Jan 11, 2017, Published date: Jan 18, 2017

Copyright: 2017 © Zaky EA. This is an open-access article distributed under the terms of the Creative Commons Attribution License, which permits unrestricted use, distribution, and reproduction in any medium, provided the original author and source are credited.

Abstract

School refusal is problematic to the child and his family because modern societies value education and make primary schooling compulsory. Its prevalence is about 2% among school aged children and it represents 5% of children's referrals because of a suspected pediatric mental disorder. School refusal is not a diagnosis but an alarming manifestation of many problems involving the child, family, and or school. After detailed physical and mental evaluation, intervention must be tailored individually and it entails a combination of Cognitive Behavior Therapy, Family Therapy, Pediatric Mental Health Education liaison, and the intake of appropriate medications for any discovered associated pediatric mental disorder. The success rate of proper management of school refusal is about 70%. The younger the child, the milder the associated symptoms, and the earlier the intervention, the better the prognosis.

Keywords: School refusal; School phobia; School avoidance; Truancy; Separation anxiety; Back to school approach

Introduction

Sandy, an eight-year old girl, came to see me at my office with her mother who was extremely worried about her child. Sandy has always had difficulty attending school but since she started her third grade 3 months ago, her problems have significantly worsened. Every morning, she begs her mother to stay at home and when her mother refuses, she develops tantrums delaying her from getting ready to go to school, consequently she often misses her school bus. After arrival at school, Sandy frequently starts to cry from stomachache, headache, or sore throat because of which she visits the school physician and pleads to call her mother. Her mother used to pick her up early more than once weekly. At home, Sandy spends her time watching television and holding her tablet to play games for hours. Sandy's teachers are very concerned because she misses a lot of class time which resulted in poor scholastic achievement and incomplete school chores and assignments while her mother is very worried that her child might have something seriously wrong physically.

"What is wrong with my little angel doctor????!!!! Is she seriously ill???"

After thorough physical examination and conduction of all the necessary investigations, Sandy was found to suffer from school refusal.

School refusal, school avoidance, or school phobia????!!!!

When a child frequently refuses to go to school or remain there, this is termed "school refusal". School refusal is not a diagnosis but an alarming manifestation of many problems involving the child, family, and or school. Formerly, school refusal was termed school phobia but such terminology is not always accurate as school refusal is usually a

reflection of hesitation to leave home rather than a fear from school itself [1]. School refusal differs from truancy in that children with school refusal feel anxiety or fear towards school, whereas truant children generally have no feelings of fear towards school but often feel angry or bored with it [1,2].

Significant shifts or traumatizing events in a child's life are frequently linked to school refusal as changing school, moving to another house, and loss of an attachment figure (e.g. death of a dear close relative, a favorite teacher, a pet, etc...). Interestingly, the problem of school refusal may start after holidays or staying at home for some time (e.g. because of an acute illness) and typically disappears before vacations [1,3].

Epidemiology

About 1-5% of school aged children are susceptible for the development of school refusal [4]. No socioeconomic class is immune against its occurrence and family size was found to be irrelevant but the youngest child is more vulnerable to it. Generally, school refusal sufferers have average intelligence and satisfactory academic abilities [1].

On the other hand, while some investigators claim no sex predilection for school refusal [1], others found higher female susceptibility [5]. It is significantly more encountered among children at the age of starting school (5-6 years) or transfer to higher schools (middle or high school at 11-12 and 15 years respectively) and after puberty (early teens). The older the child, the more successful the school refusal as it is not easy to force an older child to attend school [1-5].

Criteria of school refusal

The child either refuses to go to school or go there; after a lot of resistance, tears, and pleading, and frequently returns home shortly after arrival. Sometimes, the child overtly shows his fear from leaving

home or attending school but in other times the problem is masked by a wide range of physical complaints as headache, sore throat, palpitation, abdominal pain, malaise, nausea, and diarrhea. Typically, such complaints start shortly after arriving at school, end once at home, and disappears completely during weekends or vacations. On the other hand, challenging behavior as temper tantrums, oppositional attitude, defiance, avoidance, and stubbornness may be encountered as well [3-6].

Etiology of school refusal

School refusal is very problematic to the child and his family because modern societies value education and make primary schooling compulsory [1]. Its prevalence is about 2% among school aged children [5] and it represents 5% of referrals of children suspected to have different pediatric mental disorders [1].

Factors which can make a child refuses to go to school or remain there could be classified into school issues that make a vulnerable child hesitant to attend school, family and home issues that make a child reluctant to leave home, and intrinsic factors from within the child himself [4, 6]; (Figure 1). The fore mentioned factors can act solely or together to end with school refusal.



Figure 1: Categories of factors that could make a child refuses to go to school

School factors as a change of a favorite teacher, moving to a new school, loss of an intimate friend, physical punishment by a teacher, and bullying by a school mate could be identified as the precipitating factors behind school refusal. On the other hand, some children have low self-esteem and are unconfident about their performance in different school activities that make academic and social demands very stressful to them and lead to an irresistible fear from going to school. Although school refusal sufferers in general have average intelligence and satisfactory academic abilities, their academic performance may deteriorate if their fears keep them away from school for a considerable length of time [4,7,8].

The child unwillingness to attend school is usually associated by ineffective parental pressure to make their children go to school and keep them there. Usually parents are trying to justify that by the considerable distress their child is experiencing when he is forced to go school [1].

As one facet of the coin, *family processes* that make a child reluctant to leave home include poor home discipline and lack of enforced house rules that is very common when the mother is single or the father is ineffective, over involvement with the child emotionally as in cases of a precocious child, anxious parent, or a mother that is very keen to be loved by her child which makes her avoid to be firm with him or her to get and maintain his or her approval, and lastly poor parental communication abilities that may explain their inability to discuss irritating scholastic issues as bullying or academic difficulties with the school administration or to seek specialized help to overcome any emotional problems they are suffering from while dealing with their child [1,4,6].

As the other facet of the coin, *the child intrinsic factors* play a significant role in school refusal. Commonly, the child has a history of previous separation difficulties but his or her previous personality may have been introvert, outgoing, or unremarkable. The child may be parental or grandparental attention seeker. The situation may be precipitated by the birth of a younger sib or an illness or death of a household close relative. Also, it is well known that most of the children especially young ones prefer to sleep late and enjoy spending their day watching television, playing with their toys, or practicing other hobbies. On the other hand, school refusal may be a presenting complaint of an underlying pediatric mental disorder as separation anxiety (especially among young children), specific phobias (related to school activities, the trip to and from school, a fear of bullies or an aggressive teacher, etc....), depression (especially in teenagers), and rarely psychosis (in adolescents) [4,7-9].

Differential diagnoses

Truancy is one of the differential diagnoses of school refusal. Truants are those who are staying away from school to engage in other activities without parental knowledge or permission unlike children who refuse to go to school or go there after a lot of resistance, tears, and pleading and frequently return home shortly after arrival with parental knowledge and approval. On the other hand, while school refusal is often a reflection of an emotional problem, truancy is linked to conduct disorder with its risk factors as male gender, poor socioeconomic conditions, large sized families, lack of home rules and discipline, marital discord, parental criminal involvement, and poor academic performance [1].

Physical illness is the most common cause of not attending schools except in teenagers when truancy rates rise. It is important to keep this possibility in mind as school refusal is often masked by a variety of somatic complaints especially if there is no improvement of such complaints during weekends or vacations. Unfortunately, settling the actual cause behind the child somatic symptoms could be difficult because an actual physical illness may be aggravated by life stressors and most children can exaggerate their symptoms when they find it rewarding (e.g. attracting more parental attention) [6].

Delayed sleep phase syndrome (DSPS) which is a circadian rhythm sleep disorder with chronic delayed sleep cycle may be mistaken for school refusal in some cases [6].

Deliberate children withholding from school by some parents for some reason or another must be explored and excluded in cases of school refusal as the anxiety of some parents may interfere with the professional ability to identify the actual cause behind school refusal. It is also worthy to remember that some parents may prefer to keep their children out of school if they do believe that education is useless or

when they need their help either at home if they are ill for instance or to gain some money by forcing them to work if they are poor [1,4,8,9].

Management of school refusal

Thorough physical examination and conduction of a battery of investigations related to the child somatic symptomatology by his or her Pediatrician are crucial to exclude any possible physical illness before referral to a Pediatric Mental Health Specialist who is supposed to do detailed mental health assessment for the child and his family. Specific questionnaires and detailed interviews with the child, parents and, teachers are very helpful to identify the problem of school refusal. Differential Power Anxiety Inventory is one of the useful multidimensional questionnaires exploring “anxiety-inducing conditions, manifestations, coping strategies, and stabilization forms” [6].

After the detailed problem identification, intervention must be tailored individually and it entails a combination of Cognitive Behavior Therapy, Family Therapy, Pediatric Mental Health Education liaison, and appropriate medications for any discovered associated pediatric mental disorder [1,6-9].

“*Back to school*” approach with rapid return to full time school is very helpful and successful when the problem is recent but if it is a chronic long standing problem, “*desensitization approach*” is better with gradual return to school policy (starting with visiting school frequently after working hours, then spending more and more time at school daily with a parent around, and lastly without). The parents must be motivated to help their child in his or her journey back to school by understanding the short term and long term academic and social disadvantages of encouraging a child to avoid school and remain at home. They have to understand the difference between cruelty and firmness in order to be consistent in dealing with their child. Family therapy is useful to enable parents to set clear boundaries, exert effective parental control, and minimize over involvement. The child is encouraged to talk about his feelings and express his fears while convincing him or her by “back to school approach” that there is nothing to be afraid of. Liaison with school personnel (administration, teachers, and school workers) is essential to let them understand the child’s problems, support him during his back to school journey, and not sending him back to home for no reason [1,4,6].

Prognosis

The success rate of proper management of school refusal is about 70%. The younger the child, the milder the associated symptoms, and

the earlier the intervention, the better the prognosis. With the best results of going back to school approach, emotional and social problems persist in about one third of the cases. A minority might develop agoraphobia or may find it difficult to go to work as adults [10].

Conclusion

School refusal is not a diagnosis but an alarming manifestation of many problems involving the child, family, and or school. After detailed physical and mental evaluation, intervention must be tailored individually and it entails a combination of Cognitive Behavior Therapy, Family Therapy, Pediatric Mental Health Education liaison, and the intake of appropriate medications for any discovered associated pediatric mental disorder. The younger the child, the milder the associated symptoms, and the earlier the intervention, the better the prognosis. Finally, it is always worthy to remember that, “wherever and whenever there is help, there is hope”.

References

1. Goodman R, Scott S (1997) School refusal. In: Child Psychiatry book. Blackwell Science Ltd, UK, USA, Canada, Australia.
2. <https://www.adaa.org/living-with-anxiety/children/school-refusal>
3. <http://childmind.org/article/when-kids-refuses-to-go-to-school>
4. Fermont WP, Smucny J (2003) “School refusal in children and adolescents”. Am Fam Physicians 68: 1555-1561.
5. <http://www.cincinnatichildrens.org/health/s/school-phobia>
6. Kearney CA (2001) School refusal behavior in youth: A functional approach to assessment and treatment. American Psychological Association, Washington DC, USA.
7. King NJ, Bernstein GA (2001) School refusal in children and adolescents: A review of the past 10 years. J Am Acad Child Adolesc Psychiat 40: 197-205.
8. Berg I (1992) Absence from school and mental health. British J Psychiat 161: 154-166.
9. Bernstein GA, Garfinkel BD (1986) School phobia: the overlap of affective and anxiety disorders. J Am Acad Child Psychiat 25: 235-241.
10. Flakierska N, Lindstvam M, Gillberg C (1988) School refusal: a 15-20 year follow up of 35 Swedish urban children. British J Psychiat 152: 834-837.