

## Teens Who Don't Go to School

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Received date: April 20, 2015, Accepted date: June 16, 2015, Published date: June 23, 2015

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### Abstract

Studies show that middle-school students who fail to attend school regularly are at risk for not graduating from high school. Of those who miss an average of one day a week, only 17% will graduate. This, in turn, has serious consequences that last a lifetime. School absence has generally been seen as a "school" problem, to be worked on by educators, school counselors, etc. What is not generally recognized is the extent to which the underlying cause of school absence is very often clinical—primarily anxiety disorders. This study describes the medical symptoms secondary to anxiety and the standard approach for evaluating the patient. It then proposes a way to identify when the underlying cause of the symptoms is likely anxiety. The earlier the cause can be identified and treated, the more likely it is for the teen to return to school.

### Introduction

#### Why this is an important issue

In a study of over 12,000 sixth graders, students who missed, on average, more than a day of school a month (that is, more than ten days a year) were found to be at risk for not graduating from high school. Of those who missed one day a week or more, only 17% graduated [1]. According to the Bureau of Labor Statistics, young adults who have not graduated from high school earn 25% less than those with a high school diploma, and only half as much as those with an AA degree. Their unemployment rate is 50% higher than those who have graduated from high school and twice that of those with an AA degree. In addition to the disadvantages in earnings and employment, in later years those who have not graduated from high school have a much higher incidence of mental illness (43%) and of poor adult function in general (in a twenty-year follow-up, 14% still lived at home and only 41% were married). They also used sick time 3 ½ times as often, despite having no higher rate of illness [2]. Boys, in particular, are at risk for never graduating. In 1959, the American Journal of Psychiatry published a study that found that after psychiatric treatment, only three of twenty-four boys and girls under eleven who had been diagnosed with "school phobia" failed to return to school. But whereas both girls in the study who were eleven or older returned to school, only three of twelve boys did so [3].

This article reviews the literature on the predominate causes of school refusal—various presentations of anxiety—and then proposes a new approach intended to identify those who are missing school because of an anxiety disorder. The earlier that diagnosis can be made, the sooner effective interventions can be initiated. The longer a teen stays out of school, the more difficult it is to return [4].

Approaches to reduce the number of teens who don't attend school. This commentary uses the model proposed by epidemiologist John Last (Encyclopedia of Public Health) for bringing about major change.

- Name the problem.
- Articulate the causes and correlates.

- Develop strategies and solutions.
- Translate those strategies into action.

**Name the problem:** "Truant" is an old French word meaning "vagrant"; the term "truancy" means "unlawful absence." The study of truancy in children had been primarily concerned with wandering, staying away from home, and refusing to attend school. Beginning in 1932, psychiatrists and psychologists began to focus more on the "juvenile delinquency" aspect and not on truancy itself. Several articles written in the 1930s discussed in detail the underlying causes of children missing school, with much of their attention being paid to "neurosis," now generally called "anxiety." There was particular emphasis on the role of mothers whose anxiety led to separation anxiety in their children, making it very difficult for the child to leave the home to attend school.

As this construct became accepted over the years, the phrases used for not attending school were less often truancy [5] and more often school phobia [6]; school anxiety; school avoidance; and, most recently, school refusal. These are all aspects of the problem, but none covers the underlying causes. Naming the problem "Teens who don't go to school," (or "failure to attend school") describes the behavior itself, without attributing it directly to one cause. That, in turn, opens up the interventions to more than simply choosing one aspect of the problem. [However, the phrase "school refusal" is generally used in this paper because that is the most common description of this problem.]

**Definition of "school refusal": youths aged 5-17 years who are:** Entirely absent from school and/or attend school initially but leave; go to school following crying, complaining of severe pain; or exhibit unusual distress that leads to pleas for future absenteeism.

Duration of at least four weeks

Onset before eighteen years of age

Causes clinically significant distress or impairment

At least 5% of children refuse to attend school or remain in class an entire day; the problem affects up to 28% of youth some time in their lives [7].

• **Articulate the causes and correlates:** Giving the problem a precise name leads to an analysis of “causes” as opposed to already settling on a cause by virtue of using a diagnosis, like “phobia,” or a strategy, like “avoidance.” In almost all cases, the underlying cause for school refusal is anxiety [8]. Anxiety disorders are often manifested by a child/teen awakening with abdominal pain and/or nausea or a headache, feeling “too sick” to go to school. Parents usually allow their child to stay at home once or twice. If the symptoms persist, they then take them to their pediatrician. The doctor’s examination will seldom find an abnormality and the parents will be reassured that it is a “virus” or some other problem that will be resolved with taking it easy, drinking fluids, etc. If the symptoms persist, the parents return and the doctor may then refer the patient with abdominal pain to a gastroenterologist, who will do x-rays and other procedures, all of which will be normal. Irritable bowel syndrome (IBS) may exhibit similar symptoms as anxiety, but, by definition, symptoms related to defecation must be present. Anxiety as the underlying cause, if considered at all, would be suspected after this work up, not before.

Less often the presenting problem is headaches. The pediatrician would likely come to the conclusion that the patient is experiencing tension headaches. “Chronic daily headaches” may seem like a possible diagnosis, but headaches in teens with school refusal clear up by afternoon, and are not present on weekends or school vacations, neither of which would be found with chronic daily headaches. Again the physician may refer the patient to a specialist, this time a neurologist, to look for an organic cause for the headache. At times the teen is indeed ill, but even those problems may be secondary to social anxiety. For example, teens with diabetes need to measure their blood sugar mid-day, and give themselves an injection of the appropriate dose of insulin. Often they do not want to be seen as “different” and, therefore, skip that dose, making it more likely that they will be too sick to attend school the next morning. Other examples include teens with asthma who are embarrassed to use an inhaler at school, and those who need to take medication with dinner, but when they are having dinner with friends they do not want to stand out. The generally-accepted model used to understand the dynamics of school refusal behaviors has two factors, each of which has two sub-factors.

**Anxiety based**

**Fear of going to school-other students:** Bullying or being humiliated (the combination of that with performance anxiety is often called “social anxiety”); a phobia (e.g. fear of a school bus, school bathroom);

Unexcused absences in a month	School is required to	Other
one	Inform parent	
two	Initiate parent conference	
five	Enter into contract with parent and teen	Case can be referred to a Truancy Board
Seven, (or ten in the academic year)		School district may file a truancy petition with the juvenile court
If not in compliance with court’s order	File a contempt motion	

**Table 2:** Primary psychiatric disorders among youths with can’t or won’t go to school.

This law requires that a plan be agreed upon by the parent, the teen, and the school for the return to school. If the plan is not followed, the

a certain teacher; anxious perfectionism; academic problems; performance fears. Fear of leaving home-separation anxiety and/or creating anxiety in their mother by being away from home.

**Tangible rewards**

Coddled at home: Extra attention/food, and/or being able to use TV, computer, video games. Leaves for school but never arrives, or arrives and leaves early. Hangs out with friends, smokes marijuana, has fun. These teens are generally called “truant”; they often end up in the juvenile justice system. Truancy specialists find almost all of these teens to have significant, but unrecognized, anxiety. Personal discussion with a group of truancy specialists (Table 1). Primary psychiatric disorders among youths with can’t or won’t go to school [9,10].

Diagnosis	Percentage
Separation Anxiety Disorder	22.4
General Anxiety Disorder	10.5
Oppositional Defiant Disorder (ODD)	8.4
Depression	4.9
Specific phobia	4.2
Social Anxiety Disorder	3.5
Conduct Disorder (CD)	2.8
Other	4.2
None	32.9

**Table 1:** It is likely that most of the 33% without a clinical diagnosis have undiagnosed anxiety. In addition, as noted, a high percentage of those with ODD or CD may also have anxiety.

Society’s efforts to improve school attendance have used laws or regulations (Table 2).

**Truancy laws**

All states have some form of truancy legislation, but there is great variation from state to state. Example: State of Washington Truancy Law (Becca Bill) <http://www.k12.wa.us/gate/truancy>

consequences can be a fine of up to \$500 and/or a weekend or more in juvenile detention.

Other states define truant in different ways, such as missing five days or more in a year, or being absent for three consecutive days. In Illinois a parent is notified within two hours of their teen not being in school. Consequences also vary state by state. For example, some suspend the teen's driver's license or revoke work permits.

### Controversies

Are the money and effort put into these efforts worth it? The negative effects are: Criminalizing teens, police stopping students with legitimate reason to be absent. Fines will inevitably be paid by the parents, so there are no consequences for the teen. An important area of difference from one state to another is the maximum age for mandatory school attendance. Many states set it at sixteen, but some require attendance until age eighteen. Adding two more years increases the work needed to respond to attendance problems substantially with, likely, minimal benefit.

### School board regulations

The school board makes decisions that can increase or decrease the frequency of truancy. In general, "zero tolerance" policies create more problems than they solve. Their rigidity causes more teens to be marked truant, leading to more suspensions.

A policy that punishes frequent tardiness by suspension hardly helps students who want to avoid school. In-school suspension or mandatory Saturday classes are more effective.

The earlier the intervention, the less likely it is that school refusal will develop. A policy of prompt notification of absent/tardy to parents (e.g., two hours, as in Illinois) will likely reduce truancy. Experts all agree that the earlier the intervention, the more likely it is to be effective [9].

**Develop strategies and solutions:** Only after a problem has been properly named, and the correct causes identified, can useful strategies be developed. In the words of Mencken, "Explanations exist; they have existed for all time; there is always a well-known solution to every human problem - neat, plausible, and wrong"

"The Divine Afflatus" in New York Evening Mail (16 November 1917); later published in Prejudices: Second Series (1920) and A Mencken Chrestomathy (1949).

This article does not make the errors Mencken identifies: the solution it proposes to this human problem is new, not "well-known"; and it is hardly "neat." It lays out two new strategies: an important role for physicians, and a collaborative effort that involves both physicians and school resources.

### For physicians

Physicians (primarily pediatricians) can reduce the number of teens who miss school by screening for attendance regularly. For example, the intake form used for an annual exam could add the question "Have you missed at least ten days of school over the past year?" Those patients who answer "yes" would then have a structured interview with the doctor or a member of their staff to determine the possibility that an anxiety disorder was an underlying cause.

This methodology is similar to that what is now used for screening for depression. The American Academy of Pediatrics recommends that pediatricians add two questions to their annual visit questionnaire, the PHQ-2:

**In the past two weeks, have you been bothered by:** Little interest or pleasure in doing things? Feeling down, depressed, or hopeless?

If the answer to either is "yes," a detailed evaluation should be done.

The pediatrician would first eliminate a severe medical problem (e.g., extended hospitalization, or serious injury) as the basis for the frequent absence [Studies have found that missing school for common complaints such as acute respiratory infections or period pains amounted to only a few days a year, on average [11]. Then, if there is no such problem, the patient would be assessed for an undiagnosed anxiety disorder. For example, they would be asked if they are missing school because they wake up with abdominal pain, or nausea. If so, do they feel better as the day progresses? Do they experience the symptoms on weekends or vacations? [The same questions would be asked for patient complaining of headaches upon awakening.] Has an MD been seen for any of these episodes and if so, what was found and/or recommended?

In addition, the patient would be screened for an anxiety disorder with the GAD-2. Over the past two weeks, how often have you been bothered by the following problems

Feeling nervous, anxious or on edge?

Not at all; several days (1);  $\geq$  half the days (2); nearly every day (3)

Not being able to stop or control worrying?

Not at all; several days (1);  $\geq$  half the days (2); nearly every day (3)

If the GAD-2 score is three or greater, or if the answers to the questions listed above indicate the possibility of a functional rather than organic problem, patients should be referred for an in-depth evaluation for anxiety. For patients without a history of a serious medical problem who have missed twenty days or more, it is critical that they be tested for an anxiety disorder. Another way to uncover the possibility of anxiety is by learning the patient's "story."

**Richard MacKenzie, a specialist in adolescent medicine, discusses the following approach**

What can we learn from Humpty Dumpty?

What was Humpty Dumpty doing before he sat on the wall?

When was he put on the wall? (high-risk situation)

Who put him on the wall? (eggs cannot climb a wall)

How was he lifted onto the wall and balanced?

Why was he put onto the wall?

What was happening prior to the patient's symptoms (nausea/vomiting; abdominal pain; headache) or school refusal began?

### Case 1: A teen with nausea and vomiting

T was a 14 year old boy who complained of nausea and vomiting upon awakening since the beginning of the school year. He had no symptoms on weekends. His pediatrician found no medical problem that could account for these symptoms so referred him to the gastroenterology clinic of the local children's hospital for an evaluation.

An extensive workup found no abnormalities; he was then referred to the Adolescent Medicine clinic. The visit began by asking T about his "story." When did these symptoms begin? "At the beginning of the school year." How was his summer? "OK-some nausea." When was the last time he felt entirely well? "Early July." Did something happen in

early July? "My father came home from work and beat up my mother so bad that she called the police." T went on to say that his father had been removed from the household for several months and was participating in an anger management program. But, he had come back to live with his family at the beginning of September. How is everything now? "Great." Are you happy your father is home? "For sure." When we asked his mother, "How do you feel every time you look at your husband?" she began to cry. It became clear that T was afraid his father would beat up his mother when he was away at school, so he found himself too sick to leave the house. [We recommended that his mother see a therapist but she did not return for follow-up despite several reminders-and also stopped returning our phone calls.

### Case 2: A teen unable to leave his room

D was a 13-year-old boy who had not been to school in a year, and barely left his room, let alone the house. He said he was terrified every time he tried to walk out the door. He managed a weekly visit to a counselor whose office was two blocks away; otherwise D was housebound. After several months of medication with no improvement, D finally felt enough trust in his physician to begin to talk about his situation. He lived with his mother and his 27-year-old stepbrother, a recovering heroin addict. D's mother was unwilling to tell her older son he had to find another place to live even though her younger boy lived in terror of the frequent visits of his stepbrother's heroin-addicted friends. He was afraid to go downstairs because his brother and his friends were there. D's father had moved out because of conflicts over the older boy's behavior. Despite extensive discussions with D's mother, pointing out that she was sacrificing her younger son by refusing to remove her older son, she would not make a change. We called child protective services whose caseworker found a safe place for D, living with an aunt who was happy to have him. He was now able to attend school. These stories uncovered serious anxiety that could not have been diagnosed any other way.

### Recommendation: collaboration between physicians and schools

For tardiness or absence: The school is, of course, the first to know about tardiness and absences. The initial step the school generally takes is to contact the parent and ask for an excuse note. As noted above, some school systems require a meeting after one episode of the parent knowing nothing about the tardiness or absence; others wait for several episodes before the parent and teen are called in for a meeting.

After a defined number of absences that are justified by a letter from a parent (at times forged by the teen), schools will ask for a physician's note. An important piece of this recommended approach is to educate physicians not to write excuse notes unless they themselves made the determination that the patient should not attend school. Students who attend school, but experience abdominal pain or headaches, are usually seen by the school nurse. The nurse generally lets the student rest for an hour or so; if the student is still experiencing symptoms the standard procedure is for the school to call a parent and ask that the child be taken home. School nurses (perhaps with the permission of a parent) could be taught to use holistic methods (e.g. breathing or relaxation exercises, therapeutic imaging) for a student with no fever or other signs of an organic problem. Many of these students would then be able to return to the classroom.

The nurse could also explore the possibility that the student was sick because they skipped taking medication, or did not use an inhaler or test their serum glucose level. They could then review with the student the risk of not following medical advice. If there was no change they

would then recommend to the pediatrician that the student be evaluated for anxiety.

Interdisciplinary "return to school" program. School officials would bring together a number of resources to establish a plan. That would include an assessment by some or all of the following:

- School teacher, counselor, administration
- Patient's physician
- Mental health provider
- Truancy specialist

Many schools already have a similar approach; the innovation proposed would be to involve the student's physician, if he or she believed that anxiety was a contributing factor to the absences. An individualized plan would be developed that would be tailored for that student. For example, if the team can identify certain classes or teachers where the student experiences severe anxiety, the school would then arrange for accommodations for this "disability." That might mean a change of teachers, or having the present teacher to agree not to call on the student in class unless they raised their hand. Any resistance by the school principal would be overridden by the physician clarifying that the student has a "disability"; Section 504 of the Rehabilitation Act of 1973 requires that reasonable accommodations be made in these situations.

### Translate those strategies into action:

And the strategies need to lead to actions that mitigate the underlying problem-in this case failure to attend school.

### At the level of society

- Re-evaluate truancy laws state-by-state. Determine what has worked best, based on cost-benefit analysis (that is, which states are able to return the most students to school at a relatively low cost). Most states mandate school attendance until age sixteen. For those states that require school attendance to age eighteen, the costs and benefits of that law should be studied.
- Relook at school board rules on "zero tolerance" regulations and the cost and effectiveness of having police officers in schools; and study the effects of out-of-school suspensions as opposed to "in-school" suspensions.

### At the level of clinicians:

- Teach primary care providers the importance of screening for school absence.
- Encourage them to add a question to their routine questionnaire that asks about school attendance.
- Develop a tool that can be used by physicians or their clinical staff to determine which teens are likely to be missing school secondary to anxiety.

### At the level of schools

- Review the most helpful way to define "truant" and then minimize "no tolerance" definitions. Some teachers seem to believe that if rules are not strictly enforced they will not be effective. For example one teacher marks students as truant if they are not in their seat when the bell rings (standing in front of their seat does not count as present). Another teacher locks the door to the classroom at exactly the moment the period begins, thereby preventing students who are even a second or two late from attending class, causing them to be recorded as "truant."

- Assess the school policy on when children and teens with medical symptoms need to be sent home. The school nurses can be taught to work through a checklist and if it is likely that the symptoms are secondary to anxiety, to utilize the holistic treatments referred to above prior to calling parents to ask them to pick up their children.

These changes in school policies may not be enough.

Ultimately the only effective treatment is... going to school. In an article discussed earlier, Rodriguez wrote the following (still useful more than sixty years later): "The central focus of the treatment program in all cases should be placed on the insistence on early return to school, reinforced by appropriate sanctions of authority." Ways to accomplish this include:

No home schooling (see below for exceptions);

Not changing school (it is rarely helpful);

Schools need to be less strict in enforcing rules.

That, in combination with more involvement of parents and children, leads to better attendance levels.

The two cases discussed above are extreme. It is much more common for teens to have an underlying anxiety disorder that has led them to feel overwhelmed by the prospect of being embarrassed at school. Some experience severe anxiety when they are away from home. Many miss school secondary to both types of anxiety. Brief therapy using cognitive behavioral strategies can be helpful, and can be supplemented by parent training on contingency management.

Exposure therapy can also be helpful [9]. A typical plan would involve driving the student to the school on Day One; getting out of the car on Day Two; walking up to the front door on Day Three; entering the school and going to the counselor's office on Day Four; and then, after one week, choosing one class to attend daily. Generally the teen will work up to at least a half-day; in some cases, the school needs to be flexible and allow the student to do highly structured work at home for the remaining classes.

It can also be helpful for a teacher or a therapist to spell out the path the teen will be on if they do not return to school. Most of these students have good intelligence; even without returning to school many will obtain a GED. But studies show that GED recipients do not enroll in postsecondary education at the same rate as do high school graduates. According to the National Center for Education Statistics, of the three million high school completers in 2013, 66% enrolled in a 2- or 4-year institution of higher education the following fall. By comparison, a 2011 study by the Center found that only 31% of 2003 GED recipients had enrolled in a postsecondary institution within five years, and the majority of those enrolled for just one semester [11].

There are more than 40 million youth ages ten to nineteen in the United States. Based on the estimates of Kearney and Silverman discussed above, perhaps ten million of them will struggle with school attendance at some point and two million will be missing most of their classes or no longer attending school at all. This has serious consequences for the student and for society as a whole.

This article clarifies the most common cause of frequent school absence-anxiety disorders. It proposes that to reduce school absence, pediatricians become involved with this problem. The first step would be to educate them on the important role anxiety plays, and then to recommend that they screen their patients annually for the possibility that a patient is missing school, by adding a single question to the intake form they use for annual visits. They would then need to determine the likelihood that the primary problem was secondary to anxiety, not to an organic disorder. It discusses several methods for diagnosing anxiety disorders and then goes on to recommend an innovative interdisciplinary approach for schools and physicians to work together to help students return to school.

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