

Personal practice

Management of school refusal

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There are two principal aims in the treatment of school refusal. The first is to get the affected child back to school¹ and the second to alleviate associated psychiatric disorder.²

Early return to school

For a quarter of a century it has been considered important to restore regular, trouble free school attendance as soon as possible.³ The alternative approach of taking the pressure off the child to go back to school while treatment for psychiatric disturbance is carried out has found little favour in recent years and is not to be recommended. The policy of arranging home tuition and allowing the child to stay off school for weeks or months has not been a success. It is still practiced and should be stopped.

Psychiatric disorder

Children with school refusal become severely disturbed emotionally when they are away from school and are under considerable pressure to go. Anxiety is often very evident and frequently manifests itself as physical symptoms such as abdominal pain, nausea, anorexia, vomiting, diarrhoea, frequency of micturition, or headache. Staying home, clinging to parents, misery, worrying, and resistivity to parental requests are characteristic features. Many of these severe symptoms resolve rapidly once normal attendance is resumed, although some features of neurotic disorder of varying degrees of severity often persist for months or years.⁴ The management of these problems does not differ from the treatment of neurotic difficulties uncomplicated by school refusal, so will not be considered in any detail here.

The greater part of this article will be devoted to ways of getting school refusers back to school, since these are specific to this particular condition and are normally used as a first step in treatment.

Methods

Parental counselling. It is always a good idea to arrange regular meetings with parents, perhaps on their own at first, but with the affected child and possibly others who live in the house participating in the discussions later on. The purpose of these sessions is to give parents support and to help them accept the idea and adopt attitudes and behaviour commensurate with an early return to school. They may be able to help the child go to school by rearranging their lives a little; for example, by father changing his hours of work so that he can help mother cope with the tempers, miseries, and obduracy which are often so evident when any pressure is exerted to get the child to get ready and go to school. Taking a child to school in the car may make all the difference. It is often only when the child senses that the parents are determined to enforce attendance at school that progress is made. Unfortunately parents of school refusers, especially mothers, tend to be somewhat over protective⁵ and find it difficult to provide the firm consistent support required to help affected children overcome their difficulties in leaving home and going to school.⁶ Nevertheless, counselling techniques do seem to bolster parental resolve and aid the process of going back to school.⁷

Direct help for the child.

Counselling

It is just as important to arrange to see the child who is refusing to go to school as to spend time counselling parents. Regular individual sessions may be helpful in gaining the child's confidence and in beginning to get some degree of cooperation for an early return to school. At first the child is often unresponsive, even hostile. Many an initial interview has to be conducted through a closed door with the child locked in the bathroom or barricaded in the bedroom, perhaps threatening to take an over-

dose or jump out of the window. Later on the child is often prepared to talk about the situation and even contemplate going back to school. It may help to give the child some say in just when return to school is attempted and how it will be done. Sometimes the greater parental resolve, perhaps stiffened by their counselling sessions, and the diminution in the child's acute distress, result in the child returning to school. This may be only a week or two after the process of treatment began. Sessions with parents and child as well as other family members (if this is appropriate) may then suffice to bring the phase of management getting the child back into normal schooling, to a satisfactory conclusion.

Active assistance

Counselling techniques as outlined are not infrequently insufficient in themselves to restore normal school attendance. This is most often the case with teenage school refusers. Something else is needed. A professional worker, be it doctor, psychologist, nurse, or social worker takes a much more active role than that involved in counselling, and accompanies the child to school. The process of reintroduction to school is probably best carried out quite gently over weeks rather than days.⁸ Whether or not it succeeds seems to depend to a considerable extent on the establishment of a good relationship between worker and child. The emotional support and feelings of security that this engenders can help the child face up to increasingly demanding situations as return to school takes place.

Day placements. It is an old adage that changing school does not help school refusal, even though the affected children, and parents as well, often express the view that this would solve the problem. When that course of action is adopted, the same difficulties usually arise at the new school with the added disadvantage that the teachers there do not really know the child. A temporary expedient can be some sort of day placement. In many parts of Britain education authorities provide special units, often with transport provided, where a small group of children are given some schooling in an informal atmosphere. School refusers usually find units of this kind much more acceptable than normal school and attend regularly. These units at least serve the purpose of getting the child out of the house and into something resembling the classroom situation. Day units with schooling on the premises are also available in the National Health Service as part of child and adolescent psychiatric provisions. They have the virtue of an integrated approach combining

psychiatric treatment with a relaxed educational setting.

Residential placements. If outpatient management, and possibly a day placement, are unsuccessful in restoring normal school attendance, admission to a psychiatric inpatient unit for children or young adolescents should be considered. Hospital residential units of this kind are often run on a weekly basis so that the children can spend their weekends at home. There is usually a school on the premises. The daily regimen is geared to helping disturbed young people with emotional problems. There is usually a multidisciplinary team including psychiatrists, nurses, social workers, and psychologists, as well as teachers.⁹ It may be difficult to persuade a child who is refusing to go to school to accept admission. Once the child has settled in, however, symptoms of severe upset rapidly improve and it is much easier to plan return to school from home and to bring it about.

The staff get to know the children well during their stay of several months in the unit, so are in a good position to give them the required support when the time comes for them to go to normal school from home. The admission provides an opportunity to deal with associated psychiatric problems. Behavioural methods such as social skills training are used to increase the child's independence and self confidence. Family therapy, individual and group psychotherapy, and parental casework are used when appropriate to help ameliorate neurotic and interpersonal difficulties.⁷ In passing, it should be said that the mere existence of these units and the possibility of admission, not infrequently act as an incentive to persuade the child to make a great effort to go back to school.

The time honoured remedy for school refusal is boarding school. If the child is placed in a residential school for the maladjusted then help will be available for emotional problems. Boarding school is usually kept as a last resort when all else has failed or when home circumstances are such that the child does not get a reasonable amount of firm consistent support in relation to school attendance, which is more likely in one parent families and where there is physical or mental illness or handicap affecting a parent.

Diagnostic difficulties

It has recently been suggested that school refusal may masquerade as physical or even psychiatric illness in so far as the condition the child suffers from is not recognised as being school refusal. This situation has been called the masquerade syndrome.¹⁰

Intercurrent illnesses such as influenza; lingering infections such as infectious mononucleosis; and even severe chronic diseases like diabetes, leukaemia, and cystic fibrosis may be complicated by school refusal without it being realised. Even when it is appreciated that the child's symptoms cannot be entirely accounted for by physical illness and that psychiatric disturbance may be playing some part, the absence from school is accepted as justified by the condition and school refusal is overlooked. Once it is realised that a particular child is suffering from the masquerade syndrome the problem should be managed as if it were school refusal pure and simple. It may take some time and effort to convince parents and the affected child that school refusal is the central problem. To do so is the first step in managing cases of this sort.

References

- ¹ Hersov L. School refusal. *Br Med J* 1972;iii:102-4.
- ² Berg I. School refusal. *Br J Hosp Med* 1984;59-62.
- ³ Rodriguez A, Rodriguez M, Eisenberg L. The outcome of school phobia. *Am J Psychiatry* 1959;116:540-4.
- ⁴ Berg I, Butler A, Hall G. The outcome of adolescent school phobia. *Br J Psychiatry* 1976;128:80-5.
- ⁵ Berg I, McGuire R. Are mothers of school phobic adolescents overprotective. *Br J Psychiatry* 1974;124:10-3.
- ⁶ Eisenberg L. School phobia: a study in the communication of anxiety. *Am J Psychiatry* 1958;114:712-8.
- ⁷ Hersov L. Hospital inpatient and daypatient treatment of school refusal. In: Hersov L, Berg I, eds. *Out of school*. Chichester: John Wiley, 1980:303-20.
- ⁸ Yule W, Hersov L, Treseder J. Behavioural treatment in school refusal. In: Hersov L, Berg I, eds. *Out of school*. Chichester: John Wiley, 1980:267-302.
- ⁹ Berg I. A follow up study of school phobic adolescents admitted to an inpatient unit. *J Child Psychol Psychiatry* 1970;11:37-47.
- ¹⁰ Waller D, Eisenberg L. School refusal in childhood—a psychiatric paediatric perspective. In: Hersov L, Berg I, eds. *Out of school*. Chichester: John Wiley, 1980:209-30.

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