

School refusal - Psychosocial distress or Psychiatric disorder?

G Karthika^{1*}, M Gowri Devi²

¹DNB Psychiatry Resident, ²Academic Director, Asha Hospital, Hyderabad, Telangana, India

***Corresponding Author: G Karthika**

Email: karthi.athi@gmail.com

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Abstract

Background: School refusal is not a diagnosis by itself but a behavior described when a child frequently refuses to go to school or remain in school. It is often associated with several psychiatric disorders. A prevalence rate of 5-10% is described in most studies. Several psychosocial factors, individual, familial, societal, school and medical are also known to play an important role. The study intends to explore the association of school refusal to either psychiatric disorder or to distress due to psychosocial factors.

Aim: To explore the psychosocial factors and psychopathology in children presented with school refusal.

Method: A descriptive study conducted on children attending Child and Adolescent Psychiatry OPD at ASHA Hospital with primary complaint of school refusal, from January 2018 to December 2018. Data pertaining to 33 new cases of school going children between 6 years and 18 years, with school refusal as main symptom were collected using a semi structured proforma. Various psychosocial factors which were broadly classified as individual, family, school, societal factors and other medical disorders were analyzed. Psychiatric diagnosis made using ICD 10 criteria was assessed. Data analyzed using SPSS software.

Results: About 6.6% of total new child cases in the year of 2018 were with primary complaint of School Refusal. Out of these 33 subjects, 30 (91%) had a psychiatric diagnosis at baseline. Depressive disorder (36.4%) was commonest followed by anxiety disorder (18.2%), conduct disorders (15.1%) and remaining Hyperkinetic disorder, mental retardation and bipolar disorders. Psycho-social factors influenced school refusal contributing to the psychiatric disorder.

Conclusion: The study highlights school refusal as a symptom of one or two psychiatric disorder rather than psychosocial distress alone, indicating high psychiatric morbidity. Further it emphasizes that the symptom need to be taken as an emergency and intervened. This would entail child going back to the school early and avoid chronic school refusal with serious consequences of poor academics and social development and risk of psychiatric illness into adulthood.

Keywords: School refusal, Psychiatric disorder, Psychosocial factors.

Background

School refusal is described when a child frequently refuses to go to school or remain in school. It is considered to be associated with several psychiatric disorders but not as a diagnosis by itself. A prevalence rate of 5-10% is described in most studies. Many psychosocial factors like familial conflicts, parenting styles, peer-pressure, bullying at school, and change of school or life events such as death or illness are attributed to school refusal. Individual factors like IQ and temperamental factors are also known to play an important role. In country like India where elementary education is mandatory from ages 6-14 (Right to Education Act), it is still observed that there is a high dropout rate among children of that age group. Though it appears to be simple absenteeism from school, there is lot of distress associated with it and hence to be considered as a major issue having negative consequences on child's future. The study intends to explore whether the distress due to psychosocial factors or psychiatric disorders contribute to symptom of school refusal in children. Assessment of psychiatric illness associated with school refusal seems to be important in alleviating distress to the child and family in order to enhance educational and emotional development of the child.

Introduction

School refusal is a behavior seen as one of the child psychiatric emergencies. It refers to child avoiding attending school and/or difficulty in staying at school throughout.¹ There are various risk factors described to be associated with this behavior in various Indian and western studies. Children presenting with school refusal have seen to be associated with psychiatric illness.²

Various terms like school phobia, school anxiety or absenteeism have been used to describe the concept. Broadwin first described about truancy as maladjustment to situations and an emerging personality issues. Understanding the psychological conflicts in children helped in an effective approach towards anxiety related school-absenteeism.³ Later the term "school refusal" was introduced which was also noted by National Association of School Psychologists (NASP).⁴ In spite of school refusal being linked to various psychiatric disorders, it is not included in DSM V or ICD 10 because of the heterogeneity of the problem. One of the earliest studies, by Berg in 1969, described criteria for diagnosing school phobia. He further classified them as acute and chronic cases. He considered the following symptoms of; (a) severe difficulty in attending school, (b) becoming emotionally upset on attending school, (c) results in school absenteeism with parent's knowledge and (d) absence of significant antisocial disorders, as criteria for identifying school refusal. The child is described to have

an emotional upset with the prospect of having to go to school, that is expressed as excessive fearfulness, temper tantrums, misery, or somatic complaints without obvious organic cause.⁵ Another study found that negative emotional states of depression, anxiety and stress are related to school refusal, which in turn results in avoidance of negative affectivity, escape from social situations, attention seeking and reinforcement behaviors.⁶ School refusal is often seen following holiday, a long break, change in school or any life events or associated with other psychosocial factors. Most of the children present with wide variety of symptoms like anxiety, fear, clinging behavior, difficulty to sleep, nightmares, somatic complaints of headache, sore throat or stomach ache, and various other mood symptoms. And thus this behavior becomes a major issue stressful for the child, caregivers or parents as well as school staff. Unlike in truancy, here the child remains absent from school with their parent's knowledge, associated with emotional distress and with no antisocial behavior.⁷ However the studies are not clear whether the school refusal is due to underlying psychiatric disorder or distress due to psychosocial factors.

If school refusal and non-attendance persists without being diagnosed and treated, it would affect the academic and social development with risk of the underlying psychiatric illness progressing into adulthood. Hence, the need for early identification and intervention of the problem is important. Further there is lack of literature with regard to comorbidities associated with school refusal in the Indian context. A detailed evaluation of the presenting complaints, pre disposing events, collaborative history from family and school, physical and psychological evaluation and a multidisciplinary approach is often needed to understand the issue. Hence the study is taken up to explore the socio-demographic factors, psychopathology and psychiatric diagnostic categories in children with school refusal. The distribution of psychiatric disorders is also studied.²

Aims & Objectives

Aim

To explore the psychosocial factors and psychopathology in children presenting with a symptom of school refusal.

Primary objective

To assess the primary psychiatric disorders and their distribution underlying school refusal and the comorbidities if any.

Secondary objectives

To explore the psychosocial factors contributing to the school refusal and its association to any primary psychiatric disorders.

Materials and Methods

Study design

Exploratory and descriptive study

Study site

The study was conducted at the Child and Adolescent Department of Asha Hospital, which is a private psychiatric teaching hospital. It is a tertiary psychiatric center catering to the needs of Hyderabad and its neighboring areas of Telangana and Andhra Pradesh, with 100 beds. The average number of child cases attending child psychiatry OPD per day is between 10-15.

Study population

All the consecutive cases with a complaint of school refusal coming for the first time to the outpatient department of child psychiatry unit, from January 2018 to December 2018 are taken for the study.

Sample size

33 children were registered with the complaint of school refusal during the period of Jan 2018- Dec 2018.

Inclusion criteria

1. School going children between the age group of 6-18 years, belonging to both the gender.
2. School refusal as the primary complaint.
3. Written informed consent of parents.

Exclusion criteria

1. Child with serious, disabling medical/ surgical disorders as primary diagnosis.

Method

The present study is an exploratory, descriptive study of children with complaint of school refusal, in a private tertiary psychiatric care centre. All the consecutive new child cases presented with the complaint of school refusal were taken up for the study. Appropriate ethical approval procedures were followed while taking consent from subjects and also in conducting the research. A semi-structured proforma designed, to collect clinical data from parents, which includes socio demographic variables, history of present illness, developmental history, temperaments, medical history, family history and school details. The psychosocial factors are broadly categorized as individual, family, school and societal factors. Psychiatric diagnosis was made corroborating history, MSE and using ICD 10 criteria for various disorders. Specific scales and systematic psychological assessments were done later by a Clinical Psychologist. Statistical Analysis of data was done by using, IBM SPSS 21 statistics application.

Results

A total of 498 new child cases were registered in the year of 2018. Out of these new cases, 33 children presented with complaint of school refusal, which amounts to 6.6%. The mean age was 12.73 with standard deviation 2.929, minimum age was 6 years and maximum age was 17. Maximum number of children was from the age 12 years (21.2%), followed by 14 years and 16 years (12.1% each) and children below the age of 12 years constituted 27.3%.

Table 1: Shows the age distribution

Age	Frequency (n=33)	Percentage (100%)
6	1	3
7	1	3
8	2	6.1
10	3	9.1
11	2	6.1
12	7	21.2
13	3	9.1
14	4	12.1
15	3	9.1
16	4	12.1
17	3	9.1

On considering the schooling, 15 out of 33 (45.5%) children were in primary education, 12 of them (36.4%) in high school and remaining 6 (18.1%) in intermediate education.

Gender distribution shows that out of 33 children, 15 were male children (45%) and 18 were female children (55%).

With reference to religion, majority of the children belonged to Hinduism (84.8%), 12% of them being Muslims and remaining 3% Christians. Most of the children were from the urban area and belonging to middle socioeconomic status. Considering the duration of school refusal, we noticed a range of minimum 1 month to 1 year duration of the symptom.

Table 2: Table showing distribution of psychiatric disorder diagnosed for children with school refusal, is given below

Psychiatric diagnosis	Frequency	Percentage
Depressive disorder	12	36.4
Anxiety disorder	6	18.2
Conduct disorder	5	15.1
BPAD	3	9.1
Hyperkinetic disorder	2	6.1
Mental retardation	2	6.1
Nil	3	9

Among 33 children who presented with school refusal, 30 were found to be associated with psychiatric diagnosis, i.e. 91% had a psychiatric disorder that was diagnosed on assessment. 36.4% (n=12) were having depressive disorder, followed by 18.2% (n=6) with anxiety disorders, 15.1% with conduct disorder (n=5), bipolar affective disorder 9.1% (n=3) and 6.1% each with mental retardation and hyperkinetic disorder. Presence of a second psychiatric illness comorbid to the primary diagnosis was 12.1% (n=4). 9% of children could not be categorized as a psychiatric disorder.

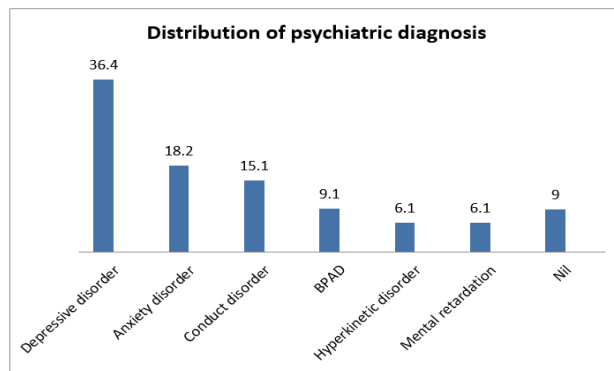


Fig. 1: Distribution of psychiatric diagnosis

Other factors like presence of medical illness, temperamental factors, and factors related to school, family and social factors were assessed. 9 (27.3%) children had medical illness (like typhoid fever, past history of febrile seizure disorder, h/o surgery and obesity) preceding onset of school refusal. About 57.6% (n=19) had temperamental issues in form of anxious traits, adamancy, sensitivity to criticism, shy, introvert etc. 10 children (30.3%) had issues at school in form of bullying by friends, issues with teachers and exams or excessive study material. Family factors in form of family history of substance abuse, psychiatric illness, death or separation of parents and discord in family were present for 48.5% of children (n=16). Social factors included history of abuse, adoption, step mother and issues with friends, which were present in 5 children (15.2%). 6 children had evident issues with parenting being permissive and excessive screen time.

Table 3: Various factors causing distress seen in this study

Medical factors: typhoid fever, past history of febrile seizures, h/o minor surgeries, obesity
Temperamental factors: anxious, sensitive to criticism, adamant, shy, introvert
School factors: bullying at school, issues with teachers, exams, excessive study material
Family factors: family history of substance abuse, psychiatric illness, death or separation of parents, discord in the family
Social factors: history of adoption, abuse, step mother, issues with friends
Other: evident issues of parenting style (permissive), excessive screen time

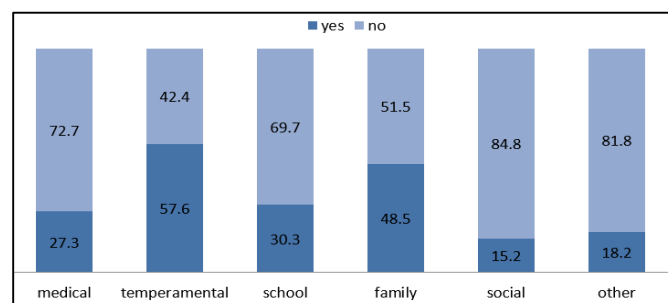


Fig. 2: Distribution of psychosocial factors assessed

Discussion

The study was done with the aim to assess the primary psychiatric disorders and their distribution underlying school refusal and the comorbidities if any. Also we wanted to explore socio demographic, psycho social factors associated with symptom of school refusal. A total of 498 new child cases were registered in child psychiatry OPD in the year of 2018. Out of these new cases, 33 children presented with complaint of school refusal which amounts to 6.6%; in contrast to the study by Nayak et al, where 3.6% of children had school refusal. This was in correlation with most of the studies showing about 3-10% of children presenting in clinics with school refusal. Studies have shown that school refusal can occur at any age but more commonly seen during a period of transition like between 5-7 years of age and 12-14 years of age.⁸ In the present study, the mean age was 12.73 with standard deviation 2.929, minimum age was 6 years and maximum age was 17. Maximum number of children was from the age 12 years (21.2%), followed by 14 years (12.1%) and 12.1% by 16 years; however 27.3% was constituted by children less than 12 years. We can see that school refusal is more common when child is in transition from primary school to high school and then again when transition from high school to intermediate. It shows that transition of grades of school and pubertal age changes results in clustering of children presenting with school refusal in that age group. This was similar with many studies which show that though all age group presents with school refusal but significant number of children are in the age group of 12 years, 14 years and 16 years of age.⁸⁻¹⁰ Among the 33 children 15 were male (45%) children and 18 (55%) were female children. Similar gender distribution is seen in other studies.⁹ There was no much differences shown regarding the gender distribution in the above studies.

In line with the findings of other studies, the study also had about 91% diagnosed with a psychiatric disorder while in study by Nayak et al it was 77.8% and majority of the diagnosed psychiatric disorder being depression (36.4%). This was followed by 18.2% (n=6) with anxiety disorders. Remaining was constituted with Conduct disorder, Attention Deficit Hyperactivity Disorder, Bipolar Affective Disorder and mental retardation. Most of the similar studies mention about depression and anxiety as major causal factor for school refusal (as per Nayak et al most common being depression (26.7%), followed by anxiety (17.7%)). They also considered few factors like academic difficulties, adjustment problems at school, behavioral problems and parental conflicts which were significant in contributing to school refusal.² A study done by Prabhuswamy et al had findings consistent with present study.¹¹ Most other studies also indicate presence of anxiety disorders as reason of school refusal together with various risk factors of family environment.¹²

Presence of psycho social stressors like medical illness, temperamental factors, school factors, family factors and social factors assessed. It was seen that around 9 (27.3%) children had medical illness like typhoid fever, past history

of febrile seizure disorder, h/o surgery and obesity. These illnesses were seen prior to the onset of symptom of school refusal. Parents initially considered it to be usual and facilitated the child to remain absent from school until the symptom started worsening. About 57.6% (n=19) had temperamental issues in form of anxious traits, adamancy, sensitivity to criticism, shy, introvert etc. 10 children (30.3%) had issues at school in form of bullying by friends, issues with teachers and exams or excessive study material. They were seen to show more of anxiety and adjustment issues to the situations. Few children had the issues with academics because of their hyperactivity, inattention or intellectual disability. Family issues in form of family history of substance abuse, psychiatric illness, death or separation of parents and discord in family were present for 48.5% of children (n=16). Social factors included history of abuse, adoption, step mother and issues with friends, which were present in 5 children (15.2%). This shows the influence of environment and relationship with others in the development of child. 6 children had evident issues with parenting being permissive and excessive screen time. As the child is having primary and secondary gains, the behavior of school refusal is reinforced, emphasizing the importance of parenting and behavioral modification. Temperamental factors along with family factors seem to trigger the symptom of school refusal in the development of psychiatric disorder. These stressors contribute significantly to the problem either directly or contributing for the psychiatric diagnosis.¹³ All these factors are strongly associated with each other resulting in chronic absenteeism. Duration of school refusal noticed was ranging from minimum one month to one year. Mental health condition impairs the cognitive and emotional development of the child and the negative effects persists into adulthood, having significant impact on public health.¹⁴ Various studies have assessed profile of children with school refusal with similar findings.¹⁵

Conclusion

Thus the study highlights school refusal as a symptom of one or two psychiatric disorder under ICD 10, rather than psychosocial distress alone, indicating high psychiatric morbidity. Further it emphasizes that the symptom need to be taken seriously as an emergency. Thus it requires detailed assessment to categorize any child with school refusal early when the parents approach for help. Assessment of psychiatric illness associated with school refusal seems to be important in alleviating distress to the child and family in order to enhance educational and emotional development of the child. Management of these cases adequately improve these children in terms of return to school and global functioning.¹¹ A synergistic approach for sensitization, assessment and management of school refusal should include the health care provider, parents, school staff, and other mental health professionals.¹⁶ The approaches include psycho social support for parents and children, cognitive behavior therapy, educational-support therapy, pharmacotherapy, and parent-teacher

interventions.⁶ The response of parents, school and medical agencies to the child's complaint and various reinforcing factors play an important role in sending children back to normal routine of attending school regularly. Few youngsters completely refuse and few attend with reluctance.⁵ This would entail the child going back to school early and avoid chronic school refusal with serious consequences of poor academic and social development and risk of psychiatric illness in adulthood.¹⁷

Strengths

1. When only few Indian studies are conducted in this aspect of school refusal, our study highlighted the increased psychiatric morbidity in this group of children.
2. The inclusion and exclusion criteria were specific.
3. The sample size was sufficient as compared to various studies.
4. The study brought out various temperamental and other psycho social factors contributing to the onset of symptoms of school refusal.

Limitations

1. Limitations due to the natural constraints of an investigation
2. Study being conducted in a tertiary center has questionable generalizability.

Recommendations and Future Directions

1. Larger sample size for better generalizability
2. To include specific scales and psychological assessment details of the child
3. Follow up of children with school refusal diagnosed with psychiatric disorders will benefit in understanding the course and prognosis and choice of tailor made treatment. It would help in relieving distress of child, parents and further serious consequences into adulthood.

Ethics

The study is conducted after taking written informed consent from subjects (In the case of minors, assent taken from the subjects, and written informed consent obtained from the legal guardian).

Appropriate ethical approval procedures were followed while taking consent from subjects and also in conducting the research. We ensure that patient confidentiality is no way breached.

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Conflicts of Interest

No potential conflicts of interest

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