

School Refusal

Mark Beitel, Ph.D.
The Westport Day School
372 Danbury Road, Suite 190
Wilton, CT 06897
203.557.0939

“Everyone has the right to education. Education shall be free Education shall be directed to the full development of the human personality and to the strengthening of respect for human rights and fundamental freedoms.... Parents have a prior right to choose the kind of education that shall be given to their children” (United Nations 1948).

Access to education is a basic human right that is protected by US law. However, some children are unable or unwilling to avail themselves of their right to education. One subgroup of these children is referred to as “school refusers.” School refusal has been defined as “child-motivated refusal to attend school or difficulties remaining in school for an entire day” (Kearney 1996). School refusal stands in contrast to truancy, which is more associated with conduct problems (Berg 1993). The estimates suggest that nearly five percent of school age children engage in refusal. It appears to be equally common in boys and girls (King 2001), though students with gender identity issues are at greater risk (Terada 2012).

Children who refuse school find themselves under a tremendous amount of stress, as do the parents and educators who work persistently to help them. As days turn into weeks, these children lose academic and social ground. School refusal is often, but not always, associated with internalizing disorders such as anxiety, depression, and somatization. King and Bernstein (2001) argued that there is evidence for three types of anxious school refusers: school phobic, separation-anxious, and generally anxious/depressed. Cognitive factors have been shown to play an important role in school refusal and its treatment. In a recent study (Maric 2012), school-refusing youth reported significantly higher levels of negative automatic thoughts than non-school-refusing peers. These thoughts had to do with perceived social threat and negative automatic thoughts concerning personal failure. The study also found higher rates of overgeneralization, a type of cognitive error associated with psychological distress. In addition, there is evidence to suggest that low self-efficacy plays a role in school refusal as well (Maric 2013). School refusers may have higher rates of learning and language disabilities than non-refusers as well (Naylor 1994). Interestingly, a small percentage of school refusing students have no identifiable co-occurring mental or physical disorder.

In order to help a child who is actively refusing school, we have to understand the meanings of, and motivations for and against, school attendance and refusal for the specific child. There are times when school refusal may be a healthy, self-protective response to an unhealthy or dangerous situation, particularly when serious, unaddressed bullying occurs. To help us understand the meaning of school refusal, (Kearney 2007) proposed a model based on the function of the behavior: (1) avoid school-based stimuli that provoke negative affectivity, (2) escape aversive social and/or evaluative situations, (3) pursue attention from significant others,

and/or (4) pursue tangible reinforcers outside of school. This model has received research support and has informed empirically-based treatment of school refusal.

Successful intervention for school refusal takes a team approach. Often this team involves the pediatrician, a psychiatrist or psychiatric nurse practitioner, a clinical psychologist, and school personnel. The pediatrician and psychiatrist can be helpful in identifying medical issues that might be contributing to the situation. They also provide medication, if needed. The clinical psychologist provides scientifically supported psychotherapy (King 2000) to address the structural and functional issues related to school refusal. School personnel are critical to the implementation of the intervention and work as important members of the team. It is vital to ensure that every member of the professional team has experience in working with school refusing children.

The goal of any intervention for school refusal is to re-engage the child in learning. The typical goal is to return the child to their school setting by removing the obstacles to engagement. This might involve addressing bullying issues or providing appropriate support. Sometimes the damage has simply been too great or the system is unable/unwilling to change sufficiently. In these instances, placement in a therapeutic school setting is the most appropriate step. Therapeutic placements may involve an educational advocate, school placement professional, and/or an education attorney. Therapeutic placements can be short-term (90 days) or year-long. Matching the intellectual, academic, and social profile of the student to the therapeutic setting is critical to success. Placing a highly intelligent child with children who have intellectual deficiencies is not likely to work; neither is placing an internalizing student with externalizers.

It is important for parents to know that there is help available for the school refusing student. It begins with careful assessment of the meanings and motives of the refusal behavior, and contributing variables, and ends with an appropriate intervention that re-engages the student in learning. Creating the right team of professionals and encouraging healthy communication with the current school setting goes a long way toward restoring access to this most basic human right.

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