

School Refusal Among Students:

A Review of Literature

by

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ABSTRACT

School attendance is critical for students' academic success. For some students, going to school is their biggest fear, which has become a growing concern over the years, not only for parents, but school personnel as well. The purpose of this literature is to explore the literature for various causal factors of school refusal and how they affect a student's willingness to attend school, and to develop recommendations for school counselors on how to address school refusal. School personnel must identify symptoms of school refusal and be able to effectively work with students and their families to diminish their concern and ensure student success. School refusal is still a significant issue that requires attention. A team approach including the student, school personnel, and parents is necessary in order to successfully treat the problem behavior. Each case of school refusal is a work in progress, and it may take some time to see results. It is important to remember that the ultimate goal of implementing an intervention for a student with school refusal is to get the child back into school with regular attendance.

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Chapter I: Introduction

In today's society, students may not feel protected at school. We cannot assume children have no fears about attending school (Jenni, 1997). There are numerous causes of a student's unwillingness to attend school. Students may have anxiety about getting on the bus for the first time, meeting new children, or simply being in an unfamiliar environment for an extended part of their day. Many parents, teachers, and other school personnel believe students simply outgrow anxieties related to school, but for some students, it continues to become a growing concern. It is imperative that many factors be taken into consideration to help solve this problem.

There are numerous reasons why youth refuse school, which is why it can be difficult to pinpoint an exact cause of their behavior. According to Kearney and Bates (2005), students usually refuse school to avoid stress, escape social situations, gain attention, or to pursue tangible rewards outside of the school. It is important that school officials, parents, and the student collaborate as teams to successfully achieve the goal of having the child attend school on a regular basis (McCartney, 2007). Berry, Inejikian, and Tidwell (1993) exclaimed the importance of not keeping a child out of school longer than necessary because the longer the/she remains at home, the more difficult it is to assure a return to school.

Statement of the Problem

School attendance is critical for students' academic success. For some students, going to school is their biggest fear, which has become a growing concern over the years, not only for parents, but school personnel as well. School refusal is a behavior that is present in approximately 5-28% of youth at one time or another (Kearney, 2006).

Students who refuse to go to school are likely to suffer both short-term and long-term effects, including difficulties in their academic and social/emotional development.

According to McCartney (2007),

Students who take a long time acclimating to the classroom setting can experience a delay in their development of self-confidence and peer-relation skills. Repeated tardiness and absences can make the child miss out on learning opportunities, interfering with the sequence of academic progress. (p. 19)

Short-term consequences of students with school refusal can include incomplete schoolwork and academic failure, alienation from peers, legal and financial difficulty, missed time from work, and substantial family and parent-school official contact (Kearney & Bensaheb, 2006). Other long-term consequences students with school refusal may experience include possible school dropout, delinquency, economic deprivation, later occupational and marital problems, and need for further psychiatric assistance in adulthood (Fremont, 2003; Kearney, 2006).

Purpose of the Study

The purpose of this study is to explore the literature for various causal factors of school refusal and how they affect a student's willingness to attend school, and to develop recommendations for school counselors on how to address school refusal. Various treatment and assessment approaches available to school professionals and parents of children with school refusal behavior will be investigated. The analysis of literature includes a summary for school personnel to identify symptoms of school refusal and be able to effectively work with students and their families to diminish their concern and ensure student success.

Research Goals

Two research goals form the basis for this review of literature. The first goal is to identify specific factors that cause a child's school refusal behavior. A second goal is to analyze these specific factors in order to determine implications for school counselors that help students with school refusal overcome their disorder. In order to ensure student success, school personnel need to identify the root of the problem that is causing students' unwillingness to attend school. Researching effective ways to collaborate with parents, school personnel, and students on the issue of school refusal is necessary in order to increase student attendance. It is imperative that school personnel also learn appropriate home-school interventions that are available so they can effectively work with students who have poor school attendance. The information provided in this study will assist school personnel in achieving success when working with school refusal students and their families.

Definition of Terms

The following terms are defined to clarify understanding of the literature reviewed in this paper. These are:

Depression: "symptomatology including dysphoric mood, fatigue, sleep disturbance, a sense of hopelessness, low self-esteem, and suicidal ideation" (Lee & Miltenberger, 1996, p. 2).

School phobia: "a disorder affecting children who have some difficulty in attending school as shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause, and a tendency to remain at home with the knowledge of the parents" (Berry, Inejikian, and Tidwell, 1993, p. 37).

School refusal: “A student’s refusal to attend school or difficulty remaining in class for an entire day” (Kearney & Bates, 2005, p. 207).

Separation Anxiety Disorder: “excessive anxiety in response to separation from the primary caregiver (e.g., mother)” (Lee & Miltenberger, 1996, p. 2).

Social Phobia: excessive fear of experiencing embarrassment in social or performance situations (American Psychiatric Association, 2000).

Specific Phobia: a persistent, excessive or unreasonable fear when encountered with, or in the presence of, a specific object or situation (American Psychiatric Association, 2000).

Assumptions and Limitations

It is assumed that other environmental factors of a child’s life impact his or her willingness to attend school. Some causes of school refusal will be more prevalent than others, depending on the age of the child with school phobia.

A limitation to this study is that insufficient research exists in the area of school refusal. There may not be enough research dedicated to effective treatment options available to be used by school personnel to address school refusal. Another limitation is the use of convenience samples in the research studies.

Chapter II: Literature Review

Introduction

School refusal among students is a perplexing and complicated problem for youth, their families, and school counselors. This chapter will discuss the topic of school refusal among elementary, middle, and high school students. First, definitions, classification, and prevalence will be explained. Second, characteristics of students with school refusal, along with the etiology and onset, will be addressed. Third, the impact of family on a student's school refusal, as well as short-term and long-term effects of school refusal, will be discussed. Finally, available treatment and assessment methods for school refusal will be discussed, along with strategies and interventions for professionals working with students and parents.

Definitions of School Refusal

School refusal and school phobia are terms that are used interchangeably to describe a particular behavior of students. According to Kearney and Bensaheb (2006), school refusal refers to dishonest absenteeism motivated by a child who refuses to attend school or who has difficulty attending classes or staying in school for the entire school day. Children or adolescents who are considered "school refusers" appear to dislike and fear aspects of school and persistently refuse to attend in an unwilling manner (Stroobant & Jones, 2006). Berry, Inejikian, and Tidwell (1993) explained school phobia as "a disorder affecting children who have some difficulty in attending school as shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause, and a tendency to remain at home with the knowledge of the parents" (p. 37). For purposes of consistency in this literature review, only the term school refusal will be used to identify this phenomenon.

School refusal can further be specifically defined by duration. According to Briesmeister and Schaefer (1998), school refusal can be self-corrected if the behavior lasts less than two weeks. On the contrary, children with acute school refusal exhibit behavior lasting between two weeks and one year that greatly interferes with the child's family life and daily routine (Briesmeister & Schaefer, 1998). Chronic school refusal lasts longer than one year and is defined by behavior that interferes with a child's life even greater than acute school refusal (Briesmeister & Schaefer, 1998).

Classification of School Refusal

There is no formal diagnosis for school refusal because children who exhibit the behaviors usually present symptoms of anxiety and mood disorders (Fremont, 2003). McShane, Walter, and Rey (2001) established that school refusal is seen as a symptom related to anxiety disorders in children and anxiety and depressive disorders in adolescents. Brand and O'Connor (2004) explained that the Diagnostic and Statistical Manual IV (DSM- IV) does not include a system used to classify whether or not a child has anxiety-based school refusal or a system that differentiates among subtypes of school refusal. Separation anxiety, social phobia, simple phobia, panic disorder, post-traumatic stress disorder, major depressive disorder, dysthymia, and adjustment disorder are all common comorbid disorders associated with school refusal (Fremont, 2003).

Brand and O'Connor (2004) stated that more than 60% of students refusing school are diagnosed with a primary anxiety disorder. Students with anxiety-based school refusal have severe difficulty attending school and emotional upset, remain at home with a parent's knowledge, do not exhibit antisocial behaviors, and acquire a heightened sense of negative affect and emotional upset (Brand & O'Connor, 2004). When a student has anxiety-based school refusal, he/she experiences anxiety regarding the attendance of

school, which leads to absenteeism (Hansen, Sanders, Massaro, & Last, 1998). According to Hansen, Sanders, Massaro, and Last (1998), children with anxiety-based school refusal tend to be older and from homes that usually do not participate in recreational activities outside of the home. These children often experience lower levels of fear than those school refusing children who have better school attendance. These less active children are likely to spend their school time at home since that is where they also spend their free time. These families may not value the development of their child's social skills by allowing them to interact with peers at school, which also makes it more comfortable for children to remain at home with their parents. Hansen, Sanders, Massaro, and Last (1998), stated that adolescents may have greater avoidance and absenteeism from school than younger children due to their complex developmental period involving coping with fears of school. In some cases, adolescents are more physically able to ignore reprimands of parents and teachers toward a return to school, which lowers their fears about possible consequences of not attending school. In contrast, Hansen, Sanders, Massaro, and Last (1998) asserted that children who are highly anxious may fear the repercussions of missing school including discipline from school officials. The realistic fears these children present could motivate the student to avoid such negative consequences.

Lee and Miltenberger (1996) classified guidelines of school refusal two ways: diagnostic classification and functional classification. Diagnostic classification includes truancy, separation anxiety disorder, specific phobia, social phobia, and depression. Functional classification includes identifying environmental factors that maintain school refusal. Diagnostic classification will be explained first, followed by functional classification.

Tyrrell (2005) asserted that most children with school refusal fall into the diagnostic categories of separation anxiety disorder, social phobia, and specific phobia depending on what causes the child's anxiety and fear. Truancy describes a child who spends his/her time away from home trying to mask school absences from parents (Lee & Miltenberger, 1996). School refusal can also be diagnostically classified as separation anxiety disorder, which can be described as excessive anxiety that results when the child is separated from the primary caregiver; students who exhibit separation anxiety disorder fear and avoid situations that involve separation from the caregiver (Lee & Miltenberger, 1996). Students who have separation anxiety and exhibit school refusal behavior tend to be females of a lower socioeconomic status who have pre-pubertal onset of symptoms. In contrast, students with school refusal tend to be males from a high socioeconomic status who have post-pubertal onset of symptoms and are likely to meet criteria for a second diagnosis (Lee & Miltenberger, 1996). A third method of diagnostic classification for school refusal is specific phobia, which can be explained as constant fear and avoidance of a confined object or situation (Lee & Miltenberger, 1996). Also under diagnostic classification is social phobia, which is similar to specific phobia. Lee and Miltenberger (1996) described social phobia as a fear or avoidance of social situations in which a student could become embarrassed. Depression is another way in which school refusal can be diagnostically classified. A large number of students with school refusal display signs of depression including dysphoric mood, tiredness, trouble sleeping, hopelessness, low self-esteem, and suicidal ideation (Lee & Miltenberger, 1996). A child's depressive signs may also be classified as dysthmic or major depressive disorder (Tyrrell, 2005).

According to Lee and Miltenberger (1996), a second way in which guidelines for school refusal can be classified is by functional classification, which involves identifying

environmental factors that maintain school refusal. Functional classification of school refusal is performed in accordance with the function of a student's behavior (Lee & Miltenberger, 1996). Lee and Miltenberger (1996) described four possible functions of school refusal behavior:

1. "Avoidance of fear/anxiety producing situations at school; the function is to avoid fear provoking situations and diminish the anxiety associated with being at school" (p. 3). This function of school refusal behavior would be similar to a student who exhibits specific phobia. This function of behavior is to avoid negative stimuli that provoke a child's fears and anxieties regarding school. Children who acquire this function are usually younger and may attend school on a regular basis but with immense dread (Briesmeister & Schaefer, 1998).
2. "Avoidance of aversive social situations at school; the function is to avoid unpleasant or anxiety provoking social contact that occurs at school" (p. 3). A student presenting this type of behavior could be exhibiting social phobia. According to Briesmeister and Schaefer (1998), individuals of this function tend to be older children and adolescents who are able to identify what is bothering them. Their attendance varies on a weekly basis.
3. "Attention-seeking; the school refusal behavior is reinforced by parents' attention" (p. 3). This function could demonstrate behavior of a student with separation anxiety or depression. Children with this function of behavior tend to be younger and may go to school sporadically after intense morning behavioral problems (Briesmeister & Schaefer, 1998).
4. "Attainment of tangible reinforcers" (p. 3). This type of school refusal behavior is sustained by tangible reinforcers such as video games, treats, meals, games, etc.

The behavior may also occur inside and/or outside of the home. Briesmeister and Schaefer (1998) stated that children of this function tend to be adolescents whose absenteeism ranges significantly.

Kearney and Bensaheb (2006) stated that 5%-28% of youth are likely to display school refusal behavior at some point in their lives. Fremont (2003) had a differing approximation of prevalence stating that only 1%-5% of all school-aged children experience school refusal. Increased rates of school refusal behavior are apparent between the ages of five and six years when children begin their education, and again around ten to eleven years of age when students make a transition from elementary to middle school (Tyrrell, 2005). Fremont (2003) also believed school refusal is more common in children who are five or six, and ten or eleven years old.

Prevalence of School Refusal

According to Briesmeister and Schaefer (1998), school refusal affects approximately 5% of school-aged children, although rates tend to be much higher in urban areas. McShane, Walter, and Rey (2001) stated that 1-2% of school-aged children experience school refusal while about 5% of adolescents display school refusal behavior. Differing opinions exist regarding school refusal among gender and socioeconomic status. Fremont (2003) believed boys and girls are equally affected by school refusal and that there is no relationship to socioeconomic status. Kearney and Bates (2005) also found that youths demonstrating school refusal are represented rather equally by gender, race, and income. However, Kearney (2006) asserted that a lack of information exists regarding ethnic differences in students with school refusal, although dropout rates for Hispanic students are considerably higher than other ethnic groups. Briesmeister and Schaefer (1998) believed school refusal occurred with equal frequency between males

and females. Despite like-minded opinions on equal prevalence of school refusal behavior among students regarding gender and socioeconomic status, some authors disagree. Brand and O'Connor (2004) believed that girls express more school refusal behavior than boys.

Characteristics of School Refusal

Students display characteristics of school refusal through their behavior in several ways. Jongasma, Peterson, McInnis, and Bruce (2006) defined the behavior of school refusers as: 1) repetitive emotional distress and complaints such as crying, temper tantrums, and begging parents not to attend school when the child anticipates separation from parents to attend school, 2) somatic complaints including frequent nausea, stomachaches, and headaches associated with attending school, 3) extreme clinging to parents when anticipating school attendance, 4) negative comments about school or questioning the necessity of school attendance, 5) unrealistic fears of harm to parents including kidnapping, murder, or being a victim of an accident, 6) verbal remarks about low self esteem and lack of confidence associated with being separated from parents, 7) verbal remarks of fear regarding failure, mockery, or anxiety about academic achievement, and 8) avoidance of unfamiliar people for prolonged periods of time.

Many children display anxious behavior in the morning about school or being separated from their parents (Kearney & Bensaheb, 2006). Tyrrell (2005) explained that child's symptoms of school refusal are the worst in the morning hours as the child prepares for school. The child may become anxious as his or her bedtime approaches and the association between getting ready for bed is linked to waking up and going to school. Some children are capable of leaving home in the morning, but they develop increasing anxiety as school approaches and are then unable to stay at school (Tyrrell, 2005).

Kearney and Bensaheb (2006) also explained that children may misbehave during the school day to visit the nurse's office to escape or avoid the classroom or to be sent home. Some students may also display somatic symptoms.

Fremont (2003) affirmed that some children with school refusal develop fear as they approach school while other children make no effort to go to school. Other signs of students demonstrating school refusal include throwing temper tantrums, crying, refusal to move, leaving school, and inhibition (Kearney & Bensaheb, 2006). In addition, children may also plead to stay home and even threaten self-harm (Fremont, 2003). Some children may even exhibit threats of suicide that may sometimes be viewed as manipulative. Children in this situation may not wish to die, but they do not want to live with the anxiety and fear of school and related behaviors of school refusal (Jenni, 1997). According to Fremont (2003), students with school refusal may also develop somatic symptoms including faintness, headaches, shakiness, chest and/or abdominal pain, nausea, vomiting, diarrhea, back and/or joint pain. These symptoms tend to dissipate if the parent allows the child to stay home from school. Children who refuse school have difficulty identifying or voicing their fear, so they act on it by avoiding school through somatic complaints (Brand & O'Connor, 2004).

School refusal and truancy differ. Children with school refusal can be found at home with a parent when they are not in school and, therefore, cannot be considered truant (Tyrrell, 2005). Fremont (2003) explained that children with school refusal attempt to persuade their parents to keep them home from school, and they are usually willing to complete their homework as long as they are allowed to do so at home. McShane, Walter, and Rey (2001) stated that school refusers often have emotional distress relating to school attendance, and these students' parents encourage them to go to school. Unlike truant

students, parents of a student with school refusal are aware of their child staying home during the school day (McShane, Walter, & Rey, 2001).

Jenni (1997) described a child's school refusal as an internalizing behavior because the child desires to attend, but is unable to do so. Kearney (2003) asserted that younger children with school refusal demonstrate additional tardiness and anguish about school, whereas adolescents skip more classes or miss entire days of school. Jenni (1997) also described students' unwillingness to attend school as externalizing behavior, which refers to truancy when students participate in activities with their peers. According to Lauchlan (2003), truancy is associated with conduct disorder whereas school refusal is linked to separation anxiety disorder. Truant students are known not to have anxiety or fear about attending school. In Japan, truant students are actually treated in guidance centers, whereas students with school refusal receive treatment in hospitals by a child psychologist and/or clinical psychologist (Iwamoto & Yoshida, 1997).

Students with school refusal and truancy often have overlapping behaviors, even though they are different in many ways. Berry, Injejikian, and Tidwell (1993) described a truant student as a child who is absent from school without the permission of parents or the school. Fremont (2003) described the criteria for diagnosis of truancy as:

Lack of excessive anxiety or fear about attending school; child often attempts to conceal absence from parents; frequent antisocial behavior, including delinquent and disruptive acts often in the company of antisocial peers; during school hours, child frequently does not stay home; lack of interest in schoolwork and unwillingness to conform to academic and behavior expectations. (p. 1555)

To summarize, children who have permission to stay home from school are considered to have school refusal, while students who do not have parental permission to not go to school are considered truant (or some kind of summary statement).

Etiology of School Refusal

The etiology of school refusal depends on the theory used to describe the phenomenon. Causes of school refusal can be understood using psychoanalytic theory, in cases when a student may be experiencing separation anxiety from his or her mother (Berry, Injejikian, & Tidwell, 1993). Berry, Injejikian and Tidwell (1993) explained that the unconscious thoughts of the children fearing the loss of their mother's love. These feelings result in the child possessing a sense of guilt expressed through aggression toward his or her mother. The mother fosters the child's overdependence by being overprotective, which is a result of the mother feeling inadequate. According to psychoanalytic theory, this over-dependent relationship is the cause of school refusal behavior. The child does not actually fear school, but is afraid to leave his or her mother.

Psychodynamic theory describes the causes of school refusal among students who exhibit feelings of grandiosity that may be threatened when faced with the realities of school. Based on this theory, the child develops feelings of omnipotence as well as a grandiose attitude of himself/herself. This omnipotence is tested in school when these students are faced with the reality of limitations (Berry, Injejikian, & Tidwell, 1993). Due to these limitations, students insist on remaining at home where their grandiose image of themselves is not threatened. According to Berry, Injejikian, and Tidwell (1993), these children actually fear an aspect of school rather than separation from a parent, which threatens their pompous view of themselves.

Behavioral/learning theories also explain the etiology of school refusal. These theories state that a child is fearful of school, or some aspect of it, due to experiences that are non-reinforcing or aversive events (teasing, scolding, physical pain), which leads to a child having anxiety and avoiding school (Berry, Inejikian, & Tidwell, 1993). Berry, Inejikian, and Tidwell (1993) explained that these children stay home to avoid anxiety (negative reinforcement) and instead receive positive reinforcement in the form of attention or rewards from parents. Based on behavioral/learning theories, the anticipation students have of returning to school causes them increasing anxiety, which is only relieved by staying home. This battle is amplified by the reinforcement of staying home.

Onset of School Refusal

The onset of school refusal behavior among students is either gradual or sudden. Fremont (2003) believed the onset of school refusal symptoms was gradual. Before youths develop school refusal they are usually average and excellent students who rarely present behavior problems in the classroom (Jenni, 1997). According to Berry, Inejikian, & Tidwell (1993), school refusal was more likely to occur at certain times or events during a student's education. Jenni (1997) described three age peaks in school refusal:

1. 5-7 years old: the child's difficulty can be considered transitory and based on ordinary to exaggerated separation issues from the parent(s)
2. later elementary to middle school years
3. high school years: students historically exhibit poor attendance

Kearney (2006) believed the most common age of onset for school refusal to be between 10 and 13 years old. Students entering a school for the first time, elementary and middle school students in particular, are at greater risk for developing school refusal behavior.

School refusal often arises when a child has remained at home for an extended period of time such as summer, holiday break, or illness (Fremont, 2004).

The onset of school refusal can be either acute or chronic. According to Jenni (1997), acute school phobia occurs abruptly for children who recently lose someone or have a serious illness. These children are previously doing well in school. Chronic school phobia develops slowly with no obvious precipitating event, years in school, or long-term family issues. Students tend to exhibit school refusal behavior after holidays, vacations, or following traumatic events such as death, moving, or changing schools (Rettig & Crawford, 2000).

Students experiencing significant loss such as death or illness of a loved one, divorce, relocation, or hospitalization may also experience school refusal (Jenni, 1997). There is no doubt that everyone experiences loss at some time in their life, but not everyone experiences anxiety disorders (Jenni, 1997). Even positive occasions such as the birth or adoption of a sibling can trigger a child to become anxious and fear school (Tyrrell, 2005). Jenni (1997) believed that a segment of this population of students may be genetically at risk to react to stress through experiencing anxiety because anxiety tends to cluster in families. School refusal is connected with anxiety disorders in younger children and with anxiety and depressive disorders in adolescents and teens (McShane, Walter, & Rey, 2001).

Students may refuse to go to school due to family stressors or stress occurring at home. Tyrrell (2005) stated that parents of children with school refusal tend to frequently demonstrate anxiety disorders themselves. McShane, Walter, and Ray (2001) believed that the primary cause of school refusal is due to enduring family or peer conflict or difficulties with academics. Some teens experience school refusal as a result of peer

harassment or difficulty upholding high grades compared with an older sibling who left home and is experiencing significant success in college (Brand & O'Connor, 2004). Jenni (1997) believed that school refusal was caused by shifts in cognitive development, modeled behavior, loss of safety in crisis situations, cognitive mistakes, and high levels of circulating epinephrine and norepinephrine that already existed, causing the nervous system to overact. School refusal may also be caused by reading and learning problems of students that were not properly identified (Heyman, 2004). Other environmental factors that may cause school refusal include death, divorce, serious illness, violence, and child abuse (Rettig & Crawford, 2000).

On the other hand, Tyrrell (2005) stated that school refusal can be caused by a small incident such as a reprimand by a teacher or simply arguing with a fellow peer. Students may even refuse to attend school because of something as minor as an argument with a friend or an even bigger issue-bullying (Kahn, 1998). Fremont (2003) believed that students who are ridiculed and bullied are at increased risk for developing school refusal, as well as other adjustment problems. Brand and O'Connor (2004) described more reasons why students may refuse to attend school including: separation issues, problems with an overly callous teacher, fear of personal safety, social phobia, depression, anxiety, difficulty with learning, and competition and other disputes of school. Some students may refuse school because they do not understand their teacher's teaching style, or, their teacher is unfriendly, and most often hostile (Lauchlan, 2003). Many students entering school for the first time fear getting lost in a new environment including the playground, school bus, cafeteria, and being around unfamiliar kids (McCartney, 2007). Fremont (2004) stated that children may also develop school refusal when they transfer to a new school.

School refusal among students has multiple causes and is a diverse syndrome that serves many functions (Fremont, 2003). Fremont (2003) described the functions of school refusal as avoiding certain fears aggravated by the school environment, flight from aversive social situations, separation anxiety, or attention-seeking behaviors that become worse over time if parents allow the student to stay home. Kearney and Bates (2005) concluded that students refuse school to avoid stressful situations, to flee aversive social or evaluative situations, to gain attention, or to pursue tangible rewards outside of school.

Impact of Family

Family dynamics are important to consider when evaluating the causes of a student's refusal to attend school because family plays a critical role in the life of a child demonstrating school refusal. Home-school collaboration is necessary in order to determine the reasons a student is failing to attend school on a regular basis. School personnel must realize that a student's explanation of absence may indeed be far from what his/her parent(s) would explain to the school. Many families may feel the school is intruding, but it is important to keep the student's best interest in mind so that he or she is able to receive an appropriate education.

There are various family changes a child can experience that may be reasons for school refusal. A student's family may be experiencing a change related to a move, illness, divorce, death, a new babysitter, neighborhood tension, economic problems, or an unexpected tragedy (McCartney, 2007). All of these family-related changes can have significant impacts on a child. Domestic abuse is also an issue to consider that may cause a student to fear the school environment. Children may fear leaving the safety of their home because they worry their parents will get hurt when they are in school (McCartney,

2007). The list of family issues is endless, which is why it is essential for school personnel to have good communication with a student's parent(s).

In some cases, parents of students with school refusal feel overwhelmed with their child's situation, so they may find it easier to give in and let their child stay home. There is no doubt that a screaming child refusing to leave his/her parent's side in public can be extremely embarrassing, which is why it is vital that school personnel be trained to handle these situations. Home-school collaboration is critical for proper interventions to be effective in dealing with school refusal behavior. Schools prefer that a child remain in the school lobby, even if it is for the entire day, versus allowing him or her to stay home (Kearney & Bensaheb, 2006).

There are several familial subtypes that further explain the impact of family on a child with school refusal. The enmeshed subtype is characterized by separation anxiety, which includes an over-involved parent-child relationship such as the mother-child dyad (Kearney & Silverman, 1995). The mother of the child with school refusal may feel incompetent in her maternal behavior, so she overcompensates by promoting a loving but overprotective attachment with her child. According to Kearney and Silverman (1995) the child may become angry, hostile, or express fear toward the mother because of the excessive affection, which can then be followed by a displacement of these emotions in the school. Children with school refusal of the enmeshed subtype tend to have high self-images that are threatened by school events such as tests that can devastate children and cause them to search for pleasure at home from an excessively permissive mother (Kearney & Silverman, 1995). Briesmeister and Schaefer (1998) explained that enmeshed families, characterized by overprotective parents, are common to children who refuse to attend school for attention or have separation anxiety.

A second familial subtype of school refusal is the conflictive family, which is characterized by hostility, conflict, antagonism, and discord (Kearney & Silverman, 1995). According to Kearney and Silverman (1995), conflict is viewed as an open expression of a confusing mother-child relationship. A mother may express hostility towards her child resulting in unclear feelings of love and hate toward the child, which results in the mother and child encouraging and discouraging school attendance depending on the existing level of negative affectivity. Based on a family systems perspective, conflict may be seen as an expression of poor boundaries between parents and children. Kearney and Silverman (1995) explained that family conflict is associated with all functional conditions of school refusal behavior and counselors should be sensitive to all family patterns while adjusting treatment accordingly.

The detached family is a third familial subtype of school refusal (Kearney & Silverman, 1995). This family subtype includes members who are not well-involved with each other's activities or considerate to each other's thoughts and needs. Briesmeister and Schaefer (1998) stated that children from detached families often refuse school for positive tangible reinforcement. The detached family tends to include withdrawn and passive fathers. Withdrawn, overwhelmed mothers of the subtype tend to seek independence from the child who refuses school in order to stay home due to fear of his/her parents abandoning him/her (Kearney & Silverman, 1995). According to Kearney and Silverman (1995), further detachment in a family may occur when a child with school refusal meets more than one formal diagnosis. The child could also be diagnosed with something such as separation anxiety or major depressive disorder.

A fourth familial subtype of school refusal is the isolated family, which is comprised of problematic mother-child interactions, child abuse, and limited, aversive

social contacts (Kearney & Silverman, 1995). According to Kearney and Silverman (1995), isolated families have little extrafamilial contact and engage in less family activities than normative families. Children of isolated families shun activities that take place outside of the home and are hesitant to seek outside intervention for the child's school refusal problem and they do not follow through with scheduled assessment, consultation, or treatment sessions. Briesmeister and Schaefer (1998) asserted that children from isolated families refuse school to escape aversive social situations at school.

On the contrary, the healthy family subtype of school refusal is viewed as having high levels of cohesion and self-expression as well as suitable problem-solving skills (Kearney & Silverman, 1995). These families contain low levels of conflict and have adaptive healthy daily functioning.

A sixth family subtype is the mixed family, which is comprised of two or more of the subtypes previously described. Mixed families include isolated, detached members that are enmeshed with conflict over poorly defined boundaries (Kearney & Silverman, 1995). Dysfunction within a mixed family can occur in separate dyads. One dyad may include an enmeshed mother-child relationship along with a detached father. A second dyad could include a family with abuse and conflict in which parents promote isolation by not allowing outside agencies to intervene (Kearney & Silverman, 1995).

Short-Term and Long-Term Effects of School Refusal

There is no doubt that school refusal creates both short-term and long-term effects for youth. Common short-term effects include distress, academic decline, alienation from peers, family conflict, and financial and legal consequences (Kearney, 2006).

Briesmeister and Schaefer (1998) also found that short-term consequences of school

refusal include social alienation, declined school performance, increased family problems, and disruption of daily activities. Kearney and Bensaheb (2006) stated additional short-term effects of school refusal including incomplete homework, academic failure, missed time from work, and considerable family and parent-school official contact. Fremont (2003) and Tyrrell (2005) listed short-term effects as poor academics, parent and family conflict, and problems with peer relationships.

Long-term effects of school refusal may include school dropout, delinquency, economic deprivation, social isolation, marital troubles, and difficulty holding employment (Kearney, 2006). Fremont (2003) explained that school refusal youth may develop lifelong panic disorders, psychiatric illnesses, and social phobias. Chronic school refusal could also result in long-term consequences such as school and legal conflicts and weakening family and peer relationships (Fremont, 2003).

Strategies and Interventions for Professionals

Addressing the issue of school refusal in youth is not an easy task, which is why it is important for school professionals to know appropriate strategies for managing the situation. McCartney (2007) stated that a team approach including the child, parent, and school officials is essential. Lauchlan (2003) concluded that the most suitable and effective technique in dealing with school refusal is an intervention, designed to meet the student's specific needs, that involves a multi-systems approach. Kearney and Bates (2005) also believed a team approach of fully trained individuals is best when developing interventions for school refusal. Members of the team may include a social worker, guidance counselor, school psychologist, principal, dean, teachers, other school officials, parents, and the child. One school official should be responsible for coordinating the treatment plan for the student and serve as the individual who answers questions, gives

clarification, and resolves problems that arise during treatment (Kearney & Bates, 2005). Cooperation and communication among parents, physicians, mental health professionals, and school officials is essential for resolving cases of school refusal behavior (Kearney, 2006). Gosschalk (2004) asserted that using the child's parents and teachers as part of the treatment process of school refusal greatly reduces the demands on the counselor's time and supports generalization to the school setting.

One of the most difficult challenges of intervention is noncompliance from one or more parties implementing the treatment plan who may be pessimistic about behavior change among the child (Kearney & Bates, 2005). According to Kearney and Bates (2005), noncompliance commonly occurs due to difficult or complex treatment plans, continuous assessments, lack of motivation, or child resistance. In situations when the child's parents are noncompliant with treating school refusal, school officials may have to be sent to the child's home to transport him/her to school, arrange transportation to school, increase the family's social support network to increase resources to assist in treatment, and make appropriate referrals to local and government agencies when necessary (Kearney & Bates, 2005). Kearney and Bates (2005) stated that some parents may deliberately keep their child home due to economic reasons, maltreatment, or because they worry about their child being harmed or kidnapped. Noncompliance in addressing the issue of school refusal can also stem from school officials. Kearney and Bates (2005) asserted that staff members may exhibit noncompliance in several ways including: insisting a child be sent home during the school day, becoming hostile toward the student, maintaining poor record keeping or monitoring of the child's behavior, assigning inappropriate class placements, and failing the student academically, which can lead to a child lacking the incentive to attend school. Gosschalk (2004) believed that

anxiety-based school refusal among students could be treated in the home when school officials lack support and sympathy for treatment. It is critical that the school counselor aids in team building for success with school officials, parents, and the student by providing leadership, encouragement, and guidance throughout the intervention (Jenni, 1997).

The issue of school refusal needs direct attention from school officials as soon as the problem arises. Quick and early intervention is required for school refusal in order to prevent the development of further problems including learning difficulties and social and emotional development problems (Berry, Injejikian, & Tidwell, 1993). According to Berry, Injejikian, and Tidwell (1993), parents and school officials must be able to differentiate school refusal from truancy in order to implement the most appropriate intervention. School counselors often acquire the role of encouraging teachers to be aware of youth with school refusal by conducting in-service programs and/or providing follow-up services (Berry, Injejikian, & Tidwell, 1993). Berry, Injejikian, and Tidwell (1993) stated that school officials must be aware of their limitations when assisting youth with school refusal and know that referral may be necessary in some cases. Obstacles that may arise with referrals could include lack of agencies, waiting lists, and family inability or refusal of agencies (Kearney & Bates, 2005).

As mentioned previously, the school counselor plays a significant role in the intervention of a student with school refusal behavior. There are several strategies school counselors can use with students including letting the student choose a morning classroom job, having lunch with a friend in the counselor's office, having an "in class" buddy, participating in a friendship group, allowing the student to call home, letting the student bring an object from home with him/her to school, or carpooling with a friend to

school (McCartney, 2007). Kearney and Bensaheb (2006) stated that school counselors can also assist students with school refusal by encouraging their return to class, rewarding successful attempts for classroom attendance, and consulting with parents and other school officials when appropriate to develop a long-term plan such as a 504 plan if necessary. Kearney (2006) asserted that gradual reintroduction to school is most appropriate, which may involve the student initially attending school at lunchtime, attending one or two favorite classes, or participating in alternative classroom settings such as the school counselor's office or library. Unless a student presents medical symptoms, it is best to have the student remain in school during the day and not be sent home (McCartney, 2007). If the student does present physical symptoms, a medical assessment should be completed. If the results of the assessment are not abnormal, parents need to be informed that their child should return to school (Berry, Inejikian, & Tidwell, 1993).

Jongsma, Peterson, McInnis and Bruce (2006) said that the counselor must establish an alliance with the child and help her/him express his/her concerns with attending school. Trust with the child can be built through consistent eye contact, unconditional positive regard, active listening, and affectionate acceptance to increase the child's ability to express his/her feelings about school attendance (Jongsma, Peterson, McInnis & Bruce, 2006). The school counselor could also help the child explore his/her negative cognitive messages that cause fear about attending school and assist the child in developing positive cognitive messages that help to increase his/her self confidence in coping with anxiety or fear. Helping the child identify positive experiences in school is another strategy school officials could use to further diminish negative cognitive messages. The school counselor could do this by exploring when the child was able to

attend school without displaying significant anxiety or distress using coping strategies. When the counselor is able to anticipate possible stressors that cause the child anxiety, he/she can assist the family identify helpful coping strategies and contingency plans to lessen the child's distress about attending school. In some cases of school refusal, the child's anxieties may be associated with past uncertain separation, loss, trauma, or improbable danger. The counselor can assist the child in exploring feelings connected with his/her past to help lessen current anxiety to attend school. Other strategies to use include training the child to be assertive to reduce social anxiety and help him/her cope with mockery by assigning readings that explain effective coping mechanisms. Encouraging the child to spend more time away from home would also be beneficial in working with a child experiencing school refusal. Increasing the child's participation in extracurricular and positive peer group activities that are away from home could also be beneficial for the child.

Other ways of lessening student's anxiety to attend school include having the school counselor set up an orientation meeting for the student, sending a letter to student's parents over the summer to clarify the school counselor's role and availability to help with student's adjustment to school (McCartney, 2007). Jenni (1997) listed other approaches school officials could help a student take such as driving by the school without entering, entering school when class is not in session, entering school later in the day, or attending one class that is easiest for the student. McCartney (2007) mentioned that school counselors can also present a classroom guidance lesson on caring that reinforces school helpers and safety that may help students feel less anxious about school attendance. Having teachers develop daily classroom routines for arrival and departure of students may also be a helpful strategy to promote school attendance (McCartney, 2007).

Jenni (1997) stated the importance of school officials telling students when there is a change in their school schedule to lessen anxiety.

When first becoming aware of a student's problem of unwillingness to attend school, there are several things that must be considered. School officials need to determine whether or not the student's absenteeism is related to parent-motivated school refusal or other factors including homelessness, maltreatment, pregnancy, illness, or legitimate threats at school (Kearney, 2003). Kearney (2003) stated that in order to determine the student's motivation not to attend school, interviews of the student's family, teachers, school counselor(s), and medical personnel should be conducted. Recent academic, housing, and medical records should also be reviewed. Kearney and Bates (2005) asserted that school officials should independently observe the student's attendance behavior whenever possible. School officials should pay close attention to a student's patterns of anxiety, depression, somatic complaints, noncompliance, aggression, tantrums, and escape behaviors, especially in the morning (Kearney, 2003). Fremont (2003) asserted that assessing a child with school refusal must include a complete medical history and physical exam to rule out any organic?? disorders.

School officials working with the parents of children who have school refusal may not be an easy task. It is important that school officials help parents understand their role in working with their children make effective changes (Fremont, 2003). Fremont (2003) found that parental involvement and caregiver training are both vital factors in improving the effectiveness of behavior treatment in children with school refusal. When working with parents, school officials need to encourage them to recognize and accept that vast problems linked with school refusal take time to resolve (Brand & O'Connor, 2004).

One strategy used by school officials in notifying parents of absenteeism is a polite “letter of concern” that outlines the student’s current situation, his/her risks for nonattendance, how the school plans to address the situation, and an invitation for parents to discuss the issue with school officials (Kearney & Bates, 2005). According to Kearney and Bates (2005), parents are receptive to a collaborative approach, and daily communication with school officials regarding the student’s attendance and homework progress would be beneficial during the intervention. Regular meetings between school officials and parents would also be helpful during the intervention in order to make any necessary adjustments and delay referral to outside agencies for further assistance with the issue.

Kearney and Bates (2005) stated that school officials need to be aware that parents are reluctant to trust them for several reasons including: being skeptical of the intervention ideas, and feeling pessimistic about the student changing the behavior. Parents often prefer a quick fix to their child’s problem, and, therefore, they may prefer to leave the issue in the hands of school officials. Parents can be difficult to track because they may choose to skip meetings, refuse to return phone calls from school officials, refuse to answer the door, or purposely keep their child home from school. Other parents may view their child’s nonattendance as a low priority because of more significant family crises such as domestic violence, homelessness, unemployment, legal and financial difficulties, or other child problems such as suicide attempts, aggression or drug use. Even though some parents may not communicate well with school officials, it is still imperative to contact the parents frequently if they feel that their child is not demonstrating evidence of improvement throughout the intervention process. Kearney and Bates (2005) asserted that evidence of improvement can be displayed to parents

through records of the student's attendance, completed work, and grades. Kearney (2006) also stated the importance of assessing a student's attendance history and patterns and occasions of legitimate absences to narrow down the reason for the student's school refusal behavior. Follow-up sessions of the intervention may also be necessary to reinforce skills and if the intervention was not successful, additional procedures including referrals with other services and agencies may be necessary to resolve the attendance problem.

According to Kearney and Bates (2005), there are several school-based and frontline techniques that can help in reducing student absenteeism. Some examples include increased monitoring student attendance, contacting parents immediately when students are absent, requiring students to have documentation for legitimate absences, assigning a student a buddy who helps him or her attend class and complete homework, frequent recognition of student attendance, using written attendance contracts that outline rewards and penalties for attendance and nonattendance, increasing student participation in extracurricular and social activities, increasing student participation in work-study programs, and temporary modification of homework assignments. Examples of more general techniques to improve student attendance may include modification of educational expectations and teacher attitudes toward a student, promoting a positive, inviting school atmosphere, reassessing a student's learning needs more frequently, providing the student with necessary and tailored instruction, embracing a diverse learning environment, creating a healthy parent-school relationship, and adjusting a student's classes and schedule as needed (citation). Kearney and Bates (2005) stated that asking a student with school refusal to commit to an attendance goal and maintain an

attendance journal signed by teachers would also be a form of treatment. Potential obstacles of the student's attendance should also be discussed.

There are some important things to consider when implementing an intervention to help dissolve the issue of school refusal. Kearney and Bates (2005) asserted that the intervention be implemented for at least two weeks before changing the strategy. The effectiveness, difficulty, and pitfalls of the intervention can be assessed during this two week period. Progress towards the final treatment goal must be clearly identified from the beginning of the intervention. It is important to maintain regular, if not daily, contact with the student's parents during the preliminary two week intervention period to resolve any initial problems that may arise. Adhering to the initial treatment intervention for as long as possible allows everyone involved in the intervention to learn their roles and carry out their responsibilities toward treatment. Adjusting the treatment plan may be necessary, which could involve changing a student's class schedule, allowing legitimate absences, attending to a student's medical issues, altering peer contacts, increasing school attendance reinforcement, improving parental commands and morning strategies, and increasing supervision of the student.

There are several strategies parents can use to aid in the intervention of school refusal with their children. Parent-child strategies may include developing morning and evening routines, providing attention-based consequences for school non-attendance, decreasing excessive child questioning or reassurance-seeking behavior, and participating in forced school attendance under strict conditions (Kearney, 2006). Kearney and Bates (2005) believe that parents should establish house rules, form written contracts, and develop rewards and disincentives for compliance and noncompliance as well as school attendance and nonattendance. Parents should also use concise commands and manage

appropriate sleep schedules for their children. Other strategies parents could use to increase their child's school attendance would be to restrict the child's activities when he/she is home from school and escort the child to school and from class to class (Kearney & Bates, 2005). Another way for parent to lessen their child's anxiety about school attendance would be to allow the child to play on the school playground over the summer and talk to the child about positive activities that occur inside the school building. Parents could also drive their children through the school parking lot to enhance familiarity of the school environment that will become more of a reality for the child in the fall (McCartney, 2007).

For those students with school refusal at the high school level, school officials will have to work with the student's parents in additional ways. Although challenging, school officials might have to help parents anticipate that graduation may not take place on time or in a traditional fashion (Brand & O'Connor, 2004). Brand and O'Connor (2004) asserted that students with school refusal may have options of completing high school in alternate forms such as an equivalency exam, coursework completion at an adult education facility, or entering a community college that does not require a high school diploma. Grief work may also be a strategy used by school officials or other professionals to help the child and parents realize that the child's dreams may be taking a different path than previously expected.

Assessment of School Refusal

Assessment is an important part of working with students who exhibit school refusal behavior. There are several different assessment tools available to professionals. One assessment with good reliability is the Anxiety Disorders Interview Schedule for DSM-IV Child and Parent Versions (ADIS for DSM-IV: C/P). According to Kearney and

Bates (2005), this assessment includes a section on school refusal behavior with questions about school-based anxiety, stimuli that may lead to fear or avoidance, and intensity and regularity of absenteeism. The School Refusal Assessment Scale-Revised (SRAS-R) is a 24 item questionnaire that assesses which functions are most relevant to a particular case of school refusal behavior such as avoidance of school-based stimuli that provoke distress, escape from aversive social or evaluative situations, attention-getting behavior, or pursuit of tangible rewards outside of school (Kearney & Bates, 2005). Kearney (2006) agreed that the SRAS-R was an appropriate assessment to use with students because it measures the strength of the four functions of school refusal to determine the primary reason of the child's behavior. There are also various child self-report questionnaires available for assessment including: the Fear Survey Schedule for Children-Revised, Multidimensional Anxiety Scale for Children, the Social Anxiety Scale for Children-Revised, the Children's Depression Inventory, and the Youth Self Report. The parent and teacher questionnaires have excellent reliability and validity including: the Parent and Teacher Child Behavior Checklist and Teacher's Report Form, and the Conners Parent and Teacher Rating Scales.

There are also numerous structured diagnostic assessments available for school refusal including the Interview Schedule for Children that generates information relative to a variety of childhood disorders, and the more specific Anxiety Disorders Interview Schedule for Children, which both have adequate reliability and moderate to high interrater agreement (Lee & Miltenberger, 1996). Another diagnostic assessment that is reliable and valid is the Children's Depression Inventory, which is comprised of 27 items that measure thoughts and behaviors that pinpoint depression. The Children's Manifest Anxiety Scale-Revised is another diagnostic assessment used for treating students with

school refusal. Lee and Miltenberger (1996) stated that this 37 item assessment of general anxiety has sufficient internal consistency and test-retest reliability. The Fear Schedule of Children-Revised is an 80 item assessment that evaluates fearfulness. It has internal consistency, test-retest reliability, and construct validity. Another assessment with adequate reliability and validity is the Social Anxiety Scale for Children. This assessment includes ten items that assess social evasion and distress as well as assessing fear of negative evaluation. Another diagnostic assessment of school refusal is the State-Trait Anxiety for Children, which is commonly used to measure children's general anxiety (Lee & Miltenberger, 1996).

Functional assessment generates necessary information to develop treatment for school refusal behavior. It includes indirect measure and direct observation of the problem behavior (Lee & Miltenberger, 1996). Kearney (2006) stated that observations are a good tool used to suggest certain treatment options for students with school refusal. One example of an indirect measure of functional assessment is the Functional Analysis Interview Form, which assesses the function of problem behaviors in individuals with mental retardation. It can be adapted to generate information from parents regarding their child's school refusal behavior (Lee & Miltenberger, 1996). Lee and Miltenberger (1996) stated that the School Refusal Assessment Scale for Children (SRAS-C) and the School Refusal Assessment Scale for Parents (SRAS-P) are both reliable and valid instruments that assess the sustaining variable of school refusal behavior. The Teacher and School Attendance Reports are also indirect measures that include attendance reports from the child, parents, and school officials conducted prior to treatment and can be used to evaluate effectiveness of treatment (Lee & Miltenberger, 1996). An example of direct observation of functional assessment is the Functional Analysis Observation Form. Lee

and Miltenberger (1996) stated that this form provides information that pertains to the function and frequency of the student's school refusal behavior. Parents are instructed to record both the antecedents and consequences of each school refusal episode until a consistent pattern is revealed that expresses a functional relationship between the behavior and the environment (Lee & Miltenberger, 1996). A second form of direct observation is monitoring. Lee and Miltenberger (1996) described the process of monitoring as having the parent record a child's daily activities while he/she is absent from school in order to help identify possible reinforcers at home that may be maintaining the school refusal behavior. Kearney (2006) also asserted the importance of assessing what tangible rewards the student receives for remaining at home during the school day. Students with school refusal can also self-monitor, which involves them completing a daily diary that provides professionals with information about the child's feelings, behaviors, and other factors contributing to the child's anxiety (Tyrrell, 2005). Parents monitor the child both before and after treatment to identify any difficulties the child may be experiencing and to evaluate the effectiveness of the treatment (Lee & Miltenberger, 1996). Teachers can also monitor student behavior. Lee and Miltenberger (1996) stated that teachers can monitor the student's difficulties with other students, avoidance of school-related activities, places, or objects, overt signs of anxiety or distress, or other problems the student is experiencing at school.

Treatment of School Refusal

School refusal is a complex issue to understand, but there are several different forms of treatment available for students and their families. Briesmeister and Schaefer (1998) highlighted the importance of relying on the fundamental ideas of our functional model to treat students with school refusal behavior. One function of school refusal

behavior is negative reinforcement, which includes avoiding characteristics of school that upset children. Children may also choose to refuse school because they want to escape social or evaluation situations that arise. A third function is when the child with school refusal desires to gain attention from significant others. Positive tangible reinforcement outside of school is the fourth function of a child exhibiting school refusal behavior. Each function of treatment for school refusal involves various treatment procedures that include parent input and training.

Hansen, Sanders, Massaro, and Last (1998) asserted that treatment should begin as soon as the student begins to experience anxiety about attending school instead of waiting until the behavior becomes more severe. For school refusers who do not attend school due to avoidance of stimuli that promote negative affectivity or to escape social situations, there are numerous treatment options available (Briesmeister and Schaefer, 1998). These include relaxation training, breathing retraining, modeling/role play, cognitive therapy, and exposure into the classroom. Kearney (2006) agreed that child-based treatment techniques such as relaxation training and breathing retraining alleviated anxiety for students. For children who do not attend school for attention or who exhibit separation anxiety, contingency management could be a helpful form of treatment. Briesmeister and Schaefer (1998) found the most successful parts of contingency management for school refusers to be 1) assisting parents in restructuring their commands so they are clear and simple, 2) creating fixed, daily routines, 3) implementing rewards when the child attends school and punishing the child when noncompliance of school attendance occurs, and 4) forcing school attendance under firm circumstances.

According to Briesmeister and Schaefer (1998), contingency contracting is a useful form of treatment for children who refuse school for positive tangible

reinforcement. Key components of contingency contracting include 1) scheduling a time and place for negotiating a solution to the problem by communicating, 2) defining the problem 3) creating a contract between the child and parents to resolve the problem at hand, and 4) making use of the contract that was created (Briesmeister and Schaefer, 1998).

Different methods of treatment are available to suit various family types. For healthy functioning families, relaxation training, systematic desensitization, and a gradual return to school are recommended (Kearney & Silverman, 1995). Kearney (2006) agreed that exposure-based practices that gradually reintroduced a student to school are effective. According to Kearney and Silverman (1995), contingency management is an appropriate treatment method for those less healthy functioning families. Parents are reestablished to co-distribute and co-reinforce the child's attendance. Contingency management includes instituted morning and evening routines, modifying parent commands toward conciseness and simplicity, providing attention-based consequences when the child does not attend school, reducing the child's excessive questioning and reassurance-seeking behavior, and forcing the child to attend school under firm conditions (Kearney, 2006). Jongsma, Peterson, McInnis and Bruce (2006) asserted that parents develop a reward system, contingency contract, or token economy that focuses on their child's attendance. The ultimate goal of contingency management is to re-shape over and under-involved parent-child relationships into relationships that have clearly defined boundaries (Kearney & Silverman, 1995). Lee and Miltenberger (1996) described contingency management as having the student's parents eliminate the consequences that reinforce the school refusal behavior. Parents also arrange punishers for school refusal behavior and consequences for school attendance. Contingency plans may also be used

by parents and school officials to deal with excessive clinging, temper tantrums, or crying after the child arrives at school (Jongsma, Peterson, McInnis & Bruce, 2006).

Kearney and Silverman (1995) stated that for the detached family, contingency contracting is an appropriate treatment option for a child exhibiting school refusal. Contingency contracting involves all family members in the treatment process by stating their complaints and projected solutions through negotiation contracts (Kearney & Silverman, 1995). Lee and Miltenbeger (1996) described contingency contracting as having the student and parents negotiate rewards and punishments upon performance of certain behaviors. The student and parents agree on terms of the contract, sign it, and receive a copy of the contract.

Treatment options for a student from an isolated family include integrating the child into activities following social skills training through the use of modeling, role play, and cognitive therapy (Kearney & Silverman, 1995). Social skills training helps the child identify social situations that cause him/her anxiety and allows the student to practice these situations with appropriate coping methods (Lauchlan, 2003). Modeling involves the student observing appropriate behavior by a model. Three types of modeling include: video modeling, live modeling, and participant modeling, which are comprised of role playing situations with the student while providing praise and feedback on the student's performance (Lee & Miltenberger, 1996). Kearney and Silverman (1995) asserted that school professionals should frequently schedule sessions and uphold contact by telephone in order to keep parents motivated to resolve their child's school refusal.

Another form of treatment for school refusal is psychoanalytic therapy. According to Berry, Injejikian, and Tidwell (1993), this therapy places attention on the student's inflated self image, which is vulnerable to the realities of school performance. For this

type of treatment, therapists place their focus on providing insight to the parents about how they contribute to the child's unrealistic self image while decreasing the child's fears of school (Berry, Inejikian, & Tidwell, 1993).

Learning and behavior therapy is another form of treatment for school refusal. According to Tyrrell (2005), behavioral approaches are primarily exposure-based and include interventions that provide relaxation techniques. One approach of this type of therapy is counter-conditioning, which focuses on altering behavior through desensitization, relaxation, and creating hierarchies of fear (Berry, Inejikian, & Tidwell, 1993). According to Lee and Miltenberger (1996), systematic desensitization, or in vivo desensitization, treatment can be used with students who experience fear and anxiety regarding school. Systematic desensitization involves three main steps of treatment. The first step is progressive relaxation training, which teaches the student how to relax his/her muscles using squeeze toys (Lee and Miltenberger, 1996). According to Lauchlan (2003) the child is taught to relax his/her bodies while also using mental imagery based on principles of classical conditioning. The intent of this type of training is for the child to develop relaxed responses when faced with the feared stimulus. Lee and Miltenberger (1996) describe the second step of systematic desensitization as developing a fear hierarchy comprised of approximately 15-20 items with the student and parents. The hierarchy includes increasingly fearful situations rated on a scale of 0 to 100 in terms of the level of anxiety induced in each situation. The third step of systematic desensitization involves systematically pairing each hierarchy situation with relaxation. The student is instructed to relax and visualize increasingly anxious situations until he/she reaches the most anxious situation at the top of the hierarchy and the student no longer experiences anxiety (Lee and Miltenberger, 1996). Berry, Inejikian, and Tidwell (1993) stated that

with systematic desensitization, the student is taught to relax as the adverse stimuli becomes introduced with increasing intensity and duration. At the same time, the child is rewarded or reinforced for his or her skill to endure the stimulus. Stroobant and Jones (2006) asserted that desensitization approaches involving a gradual return to school are often used when a forced or rapid return to school is not feasible. The student may attend half days, have limited participation, or complete homework in the school counselor's office.

Gosschalk (2004) found that behavioral interventions are commonly arranged around whether a child will have a slow or rapid return (flooding) to school. Professionals working with students who have an acute onset of school refusal often find a rapid return to school is suitable as part of the treatment plan. Jongsma, Peterson, McInnis, and Bruce (2006) concurred by stating that designing a systematic desensitization program could help a student manage his/her anxiety and continually attend school for increasingly longer periods of time. According to Lee and Miltenberger (1996), in vivo desensitization (contact desensitization) involves presenting the student with anxiety provoking situations in his/her natural environment rather than envisioning the situations. A hierarchy is still created with the same process as systematic desensitization but with exposure rather than just envisioning the situations.

Implosive therapy can also be used with students experiencing school refusal. This form of treatment allows youth to visualize themselves in anxiety-provoking situations until the anxiety is reduced while the therapist provides youth support and encouragement throughout the process (Berry, Injekian, & Tidwell, 1993).

Another behavioral technique used to treat school refusal is shaping. If the student's school attendance gradually increases, he/she is provided with appropriate and

influential rewards for their behavior. Lee and Miltenberger (1996) also described shaping as reinforcing gradual improvements of the student's behavior. Whether shaping is used to increase a child's attendance or time apart from the attachment figure at home, exposure to separation remains the common denominator for those students with school refusal who also have separation anxiety disorder (Gosschalk, 2004).

According to Lee and Miltenberger (1996), extinction may also be a form of treatment. This involves removing reinforcers for undesirable behavior and eliminating the attention maintaining the student's school refusal behavior. Parents can lessen their child's inappropriate behavior and increase desirable behavior by using shaping, extinction, and differential reinforcement of alternative and other behaviors (Lee & Miltenberger, 1996). Differential reinforcement of alternative behaviors involves rewarding the student for presenting desirable alternative behaviors so he/she will increase and replace the inappropriate behavior (Lee & Miltenberger, 1996). Lee and Miltenberger (1996) described differential reinforcement of other behavior as reinforcing the student's nonoccurrence of the problem behavior.

Two forms of cognitive treatment for school refusal include cognitive self instruction and cognitive restructuring. Tyrrell (2005) stated that cognitive self instruction involves teaching students how to use coping self-statements that deny the inappropriate behavior while guiding the positive behavior. Cognitive restructuring involves challenging and helps parents become aware of their distorted beliefs of their children. These cognitions are then substituted with more appropriate ones (Tyrrell, 2005). Kearney (2003) also embraced cognitive restructuring as a form of child-focused treatment along with psychoeducation, somatic control exercises (relaxation training), and exposure-based methods (imaginal and in vivo reintegration into school). Lee and

Miltenberger (1996) described cognitive restructuring as creating a goal of modifying the student's school refusal behavior by changing the student's maladaptive thoughts and beliefs that may be adding to the avoidance and anxiety. Cognitive restructuring allows the student to label social situations and his/her competence more positively while decreasing social anxiety and avoidance (Lee & Miltenberger, 1996).

Parent-focused treatment may include contingency management, establishing daily routines, limiting the child's reassurance-seeking behavior, and forced school attendance in certain situations (Kearney, 2003). Various family-focused treatment options are available as well including supportive psychotherapy, contingency contracting, escorting the student to school and class, and skills training in communication and peer refusal (Kearney, 2003). According to Jongsma, Peterson, McInnis and Bruce (2006), parents are encouraged to reinforce their child's self-directed behaviors and set limits on more dependent behaviors.

According to Brand and O'Connor (2004), one of children's favorite therapeutic techniques is to have a counselor help them identify their needs and wishes and then counsel them if the children desire. The child decides whether or not to be counseled, and the parents' hope is that their child will choose to accept the counselor's assistance. Educational-support therapy is an effective treatment option for students with school refusal. Fremont (2003) described this type of therapy as a combination of supportive psychotherapy and casual presentations where youth are encouraged to share their fears and identify differences between anxiety, fear, and phobias. Another available treatment therapy is cognitive-behavioral therapy, which is a highly structured approach comprised of specific instructions for youth to gradually increase their exposure to school and their fears while learning how to modify their negative thoughts (Fremont, 2003).

Treatment of school refusal can often be difficult due to time and financial constraints. Kearney and Bates (2005) recommended an abbreviated treatment approach that asks three basic questions: 1) What is the nature or form of the problem? 2) What is the function of the problem, or why does it continue to occur? 3) What is the best intervention for this problem? When no major obstacles are present, an intervention can be aimed at the most significant reason that a student is refusing school. For a student who exhibits school refusal that is more anxiety-based, he/she could benefit from child-based strategies that help diminish physical symptoms, irrational thoughts, and avoidant behaviors. If the student's behavior is primarily based on seeking attention, parent-based strategies including contingency management are useful. Contingency contracting, increased supervision, and refusing peer offers are appropriate treatment options when the student's behavior is based on obtaining tangible reinforcement outside of the school setting.

Developing treatment options for students with school refusal may bring about some challenges. Difficulties with treatment may include choosing a definite intervention, adjusting the initial plan if it is not effective, having competing views regarding the student's behavior, handling noncompliance, deciding who is responsible for implementing the intervention, dealing with limited resources, and handling referrals and follow-up issues (Kearney & Bates, 2005).

Tyrrell (2005) believed that psychopharmacological therapy should only be used if other forms of treatment therapy have been proven to be unsuccessful. Medication could be used in conjunction with other treatment therapies if the purpose is to speed up the child's return to school (Tyrrell, 2005). Fremont (2003) asserted that pharmacological treatment should never be used without behavioral and psychotherapeutic interventions.

The student experiencing school refusal needs to develop the appropriate skills to control his/her anxiety to prevent symptoms from reoccurring after the medication is terminated (Fremont, 2003). Pharmacological treatment is often used with students when they experience anxiety along with major depressive disorders (Tyrrell, 2005). In cases of anxiety and depression, medications have proven to be useful in alleviating symptoms (Kearney, 2006). According to Tyrrell (2005), the most commonly prescribed medications include selective serotonin reuptake inhibitors (SSRIs), tricyclic antidepressants (TCAs), benzodiazepines, and antipsychotics. Fremont (2003) explained that SSRIs have replaced tricyclic antidepressants as the first-line treatment for child and adolescent anxiety disorders. SSRIs are a safe and effective form of treatment for youth experiencing depression and childhood disorders (Fremont, 2003). Tyrrell (2005) asserted that SSRIs help improve youth's anxiety and school attendance, but further research is needed to determine their full effectiveness. Another pharmacologic form of treatment is benzodiazepines, which are a short-term treatment method used with students experiencing severe school refusal (Fremont, 2003). According to Fremont (2003), benzodiazepines can initially be prescribed with SSRIs to target acute anxiety symptoms. The use of benzodiazepines should be withdrawn after the SSRI generates positive effects. Fremont (2003) asserted that benzodiazepines should only be used for a couple of weeks due to the risk of dependency as well as side effects. Possible side effects of benzodiazepines include irritability, sedation, behavior disinhibition, and cognitive impairment (Fremont, 2003). Tyrrell (2005) concurred with Fremont and stated that benzodiazepines should not be used long-term due to possible addiction. It is imperative that school officials continually monitor a student's educational and physical changes while taking medication (Tyrrell, 2005).

During the treatment of school refusal with a student, there are several things to keep in mind. School professionals will be working with the student, parents, and sometimes outside physicians or therapists. It is important that the student's physician be discouraged from writing written excuses for the student's absence unless it is medically necessary (Tyrrell, 2005). Tyrrell (2005) stated that parents must agree to bring their child to school while attendance modifications are made to the student's schedule by school officials. The school counselor and/or school nurse will be necessary in the treatment process to provide the child support, encouragement, and reinforcement (Fremont, 2003). Tyrrell (2005) asserted that the student's school day may need to be modified depending on the stressors experienced by the child. School officials must reach an agreement to decide the length of the student's school day. By focusing on positive behaviors and allowing a student to spend additional time with his/her favorite teacher or the school nurse, it may be easier to help the student get through the difficult first few days of the intervention (Tyrrell, 2005). According to Tyrrell (2005), changes in classroom routines should be minimized in order to decrease the student's anxiety. Modifications of assignments and schedules in order to further lessen anxiety can be done on an individual basis. During the intervention process, the student's family and school officials must constantly remain adaptable to feedback from the child and plan interventions that will decrease failure and increase success. To ensure the most favorable outcome, treatment plan effectiveness must be monitored and evaluated to make appropriate alterations during the process (Tyrrell, 2005). Fremont (2003) asserted that home schooling the student with school refusal is the absolute last alternative form of treatment. If this treatment is the only resort, a time factor must be created and adhered to for re-entry of the child to the school setting.

In conclusion, this literature review has addressed and explored issues of school refusal. First, the definitions, classification, and prevalence of school refusal were explained. Second, characteristics of students with school refusal, along with the etiology and onset, were addressed. Third, the impacts of the family on a student's school refusal, as well as short-term and long-term effects of school refusal, were discussed. Finally, available treatment and assessment methods for school refusal were discussed, along with strategies and interventions for professionals working with students and parents.

Chapter III: Summary, Critical Analysis, and Recommendations

Introduction

School refusal is a perplexing disorder that affects individuals in different ways. For some students, the task of attending school can cause much fear. There are numerous things to consider for the cause of a student's unwillingness to attend school, such as separation concerns, family issues, fear of social situations, fear of teachers, and other school challenges. It is crucial that many factors be taken into consideration to help solve this problem. School personnel, parents, and the student must collaborate as a team in order to successfully achieve the goal of getting the child to attend school on a regular basis (McCartney, 2007). This chapter will begin with a critical analysis of literature, followed by implications for school counselors, and concluding with recommendations for future research.

Critical analysis

School refusal and school phobia are terms that are used interchangeably to describe a student's particular behavior. According to Kearney and Bensaheb (2006), school refusal refers to dishonest absenteeism motivated by a child who refuses to attend school or who has difficulty attending classes or staying in school for the entire school day. Berry, Inejikian, and Tidwell (1993) explained school phobia as "a disorder affecting children who have some difficulty in attending school as shown by such symptoms as excessive fearfulness, undue tempers, misery, or complaints of feeling ill without obvious organic cause, and a tendency to remain at home with the knowledge of the parents" (p. 37).

School refusal does not have a formal diagnosis (Fremont, 2003). However, school refusal does encompass several comorbid disorders including separation anxiety,

social phobia, simple phobia, panic disorder, post-traumatic stress disorder, major depressive disorder, dysthymia, and adjustment disorder (Fremont, 2003). School refusal can be classified in two ways. The first way is diagnostic classification, which includes truancy, separation anxiety disorder, specific phobia, social phobia, and depression (Lee & Miltenberger, 1996). The second way to classify school refusal is called functional classification, which includes avoiding fear/anxiety producing situations at school, or avoiding social situations at school, attention-seeking behavior where the school refusal of the student is reinforced by the parents, and attainment of tangible reinforcements from inside or outside of the student's home.

Kearney and Bensaheb (2006) stated that 5%-28% of youth are likely to display school refusal behavior at some point in their lives. Fremont (2003) had a differing approximation of prevalence stating that only 1%-5% of all school-aged children experience school refusal. School refusal behavior is most common as children enter school for the first time in elementary school and also as they make the transition to middle school (Tyrrell, 2005). There are differing opinions on how school refusal affects students by gender and socioeconomic status. Some authors believe boys and girls are equally affected by school refusal and that there is no relationship to socioeconomic status (Fremont, 2003; Kearney & Bates, 2005).

There are several characteristics encompassing school refusal. Tyrrell (2005) explained that children's symptoms of school refusal are the worst in the morning hours as they prepare for school. Other children are capable of leaving home in the morning and develop increasing anxiety as school approaches and are then unable to stay at school (Tyrrell, 2005). Signs of students demonstrating school refusal may include throwing temper tantrums, crying, refusing to move, leaving school, and inhibition (Kearney &

Bensaheb, 2006). In addition, children may also plead to stay home and even threaten self-harm (Fremont, 2003). Students with school refusal may also develop somatic symptoms including: faintness, headaches, shakiness, chest and/or abdominal pain, nausea, vomiting, diarrhea, back and/or joint pain (Fremont, 2003).

Fremont (2003) explained that children with school refusal attempt to persuade their parents to keep them home from school, and they are usually willing to complete their homework as long as they are allowed to do so at home. Children with school refusal can be found at home with a parent when they are not in school and, therefore, cannot be considered truant (Tyrrell, 2005).

The etiology of school refusal stems from different theories. Psychoanalytic theory explains the causes of school refusal by explaining the belief of a student experiencing separation anxiety from his or her mother. According to Berry, Inejikian, and Tidwell (1993), based on psychodynamic theory, children actually fear an aspect of school rather than separation from a parent, which threatens their pompous view of themselves. Behavioral/learning theory states a child is fearful of school, or some aspect of it, due to experiences that are nonreinforcing or aversive events (teasing, scolding, physical pain), which lead to a child having anxiety and avoiding school (Berry, Inejikian, & Tidwell, 1993).

The onset of school refusal exemplifies a common pattern. School refusal is more likely to occur at certain times or events, specifically at the beginning of a child's education, transitioning to middle/junior high school, or at the end of a student's formal education (Jenni, 1997). According to Jenni (1997), acute school phobia is considered to be "a sudden onset in a child with a recent history of loss or serious illness who was previously doing well in school; chronic school phobia includes a "slow onset, no evident

precipitating event, years of poor school performance, and long-term family issues” (p. 2).

Students tend to exhibit school refusal behavior after holidays, vacations, or following traumatic events such as death, moving, or changing schools (Rettig & Crawford, 2000). Other triggers of onset of school refusal include loss such as death or illness of a loved one, divorce, relocation, or hospitalization (Jenni, 1997). Violence and child abuse may also trigger school refusal (Rettig & Crawford, 2000). Even positive occasions such as the birth or adoption of a sibling can trigger a child to become anxious and fear school (Tyrrell, 2005). Some teens experience school refusal as a result of peer harassment or difficulty upholding high grades compared with an older sibling who left home and is experiencing significant success in college (Brand & O'Connor, 2004). School refusal may also be caused by reading and learning problems of students that were not properly identified (Heyman, 2004). Brand and O'Connor (2004) described more reasons why students may refuse to attend school including: separation issues, problems with an overly callous teacher, fear of personal safety, social phobia, depression, anxiety, difficulty with learning, and competition and other disputes of school.

School refusal can be triggered by various situations occurring in a student's life. Fremont (2003) described the functions of school refusal as avoiding certain fears aggravated by the school environment, flight from aversive social situations, separation anxiety, or attention-seeking behaviors that become worse over time if parents allow the student to stay home. Kearney and Bates (2005) concluded that students refuse school to avoid stressful situations, to flee aversive social or evaluative situations, to gain attention, or to pursue tangible rewards outside of school. There are many causes of school refusal, which is why it is essential that school personnel carefully assess each individual case.

Family dynamics are important to consider when evaluating the causes of a student's refusal to attend school because family plays a critical role in the life of a child demonstrating school refusal. Children may fear leaving the safety of their home because they worry their parents will get hurt when they are in school (McCartney, 2007). There are various family changes a child can experience that may be reasons for school such as: moving, illness, divorce, death, a new babysitter, neighborhood tension, economic problems, or an unexpected tragedy (McCartney, 2007). Differing familial subtypes may further explain the impact of family on a child with school refusal. These subtypes include: the enmeshed family, the conflictive family, the detached family, the isolated family, the healthy family, and the mixed family (Kearney & Silverman, 1995). Each subtype contains differing family issues that affect the student with school refusal in different ways. In some cases, parents of students with school refusal feel overwhelmed with their child's situation, so they may find it easier to give in and let their child stay home, which is why it is important for school personnel to take a proactive team approach (Kearney & Bensaheb, 2006). Home-school collaboration is also critical for interventions to be effective in dealing with school refusal behavior.

School refusal carries both short-term and long-term effects for students. Common short-term effects include distress, academic decline, alienation from peers, family conflict, and financial and legal consequences (Kearney, 2006; Briesmeister & Schaefer, 1998). Kearney and Bensaheb (2006) stated additional short-term effects of school refusal including incomplete homework, academic failure, missed time from work, and considerable family and parent-school official contact. Fremont (2003) and Tyrrell (2005) listed short-term effects as poor academics, parent and family conflict, and problems with peer relationships.

Students experiencing school refusal may also experience long-term effects such as: school dropout, delinquency, economic deprivation, social isolation, marital troubles, and difficulty holding employment (Kearney, 2006). Fremont (2003) explained that school refusal youth may develop lifelong panic disorders, psychiatric illnesses, and social phobias. Chronic school refusal could also result in long-term consequences such as school and legal conflicts and weakening family and peer relationships (Fremont, 2003). Being aware of both the short and long-term effects of school refusal are critical in order for school personnel to understand that the issue so that it can be handled appropriately as soon as the behavior begins to arise.

Recommendations

Although school refusal may be extremely prevalent, it is still a significant issue that requires attention. A team approach including the student, school personnel, and parents is necessary in order to successfully treat school refusal. Based on the literature reviewed, school refusal is caused by various events in a student's life and it includes many characteristics. In order for school personnel to be able to identify the causes of the student's behavior, home-school collaboration is essential.

In a school, the school counselor is a connecting individual between the student, the school, and the family. Even though school refusal is not very common, counselors must still have access to appropriate resources when dealing with this issue. The counselor needs to be knowledgeable of the characteristics and causes of school refusal in order to effectively develop interventions. Communication with a student, his/her parents, his/her teachers, and other school personnel is crucial. The school counselor must gather information from each source regarding the student's school refusal behavior. Group meetings may help pull this information together in order to work towards establishing an

intervention. Noncompliance from school officials or parents may occur, which is why it is critical for the school counselor to aid in team building for success with school officials, parents, and the student by providing leadership, and coaching throughout the intervention (Jenni, 1997).

When addressing school refusal, there are several different assessments available. The most common tool available is the School Refusal Assessment Scale-Revised (SRAS-R). This assessment is a 24 item questionnaire that assesses the student's functions that are most relevant to avoidance of school-based stimuli that provoke distress, escape from social or evaluative situations, attention-getting behavior, or pursuit of tangible rewards outside of school (Kearney & Bates, 2005). There are numerous assessments highlighted in the previous chapter that would be beneficial to use with a student experiencing school refusal. The child can perform self questionnaires and his or her parents are also able to assess their child's behavior, which promotes the collaborative team approach that situations of school refusal embrace.

Functional assessment is used in conjunction with questionnaires. Functional assessment includes indirect measurement and direct observation of the problem behavior (Lee & Miltenberger, 1996). This may be conducted by interviewing and observing the student. Viewing a child's attendance reports will also be useful during this process. The parents of the child are able to record and monitor their child's behavior at home as well. They can record the antecedents and consequences of the child's school refusal episode until a consistent pattern is revealed that expresses the function of the behavior. Monitoring the child's activities at home is also critical during assessment to help identify possible reinforcers at home that may be maintaining the school refusal behavior.

Encouraging parent participation further enhances a multi-faceted approach that deepens the understanding of the child's school refusal behavior.

The school counselor is able to use a variety of strategies when gradually reintroducing the student to school. The child could maintain a morning classroom job, have lunch with a friend in the counselor's office, have an "in class" buddy, participate in a friendship group, be able to call home during the school day, bring an object from home, or carpool with a friend to school (McCartney, 2007). If the student is allowed to do some of these things, he or she may be motivated to attend school because he or she has something to look forward to. It is better to have the student attend school for at least part of the day than not at all.

Another strategy school counselors could try is helping the child explore his or her fears about attending school and assist him or her in developing positive cognitive messages that increase his or her confidence in coping with anxiety and fear (Jongsma, Peterson, McInnis & Bruce, 2006). Once the counselor identifies the cause of the child's fears, he or she may be able to teach him or her appropriate coping strategies to use in the future so that school attendance can potentially increase over time. During this process, communication with the student's parents is essential because most parents are receptive to a collaborative approach. In some cases, parents are difficult to track, but communication, both verbal and written, demonstrates the school's efforts in creating a positive change for the student.

Implementing an intervention for school refusal requires careful consideration. The intervention should be implemented for at least two weeks before any adjustments are made (Kearney & Bates, 2005). Parents of the child with school refusal have many strategies available to them that they can use at home during the intervention process.

Some of these may include developing morning and evening routines, establishing house rules, forming written contracts, and developing rewards and disincentives for compliance and noncompliance as well as school attendance and nonattendance.

When treating a child with school refusal, it is important to rely on the functional model, which includes negative reinforcement, escape from social or evaluative situations, and positive tangible reinforcement. Numerous treatment options are available including relaxation training, breathing retraining, modeling/role play, cognitive therapy, contingency management, contingency contracting, and exposure to the classroom. Once the counselor is able to pinpoint the function of the student's behavior, the appropriate treatment option can be implemented. School counselors must realize that differing family types require certain types of treatment options that best fit their needs. Working with the student and his or her family on a consistent basis will allow the counselor to select the best treatment option for the child.

Psychopharmacological therapy may also be used to treat school refusal. Many researchers believe that it should only be used as a treatment method when all other forms have proven to be unsuccessful. If medications are used, it should only be done in conjunction with behavioral and psychotherapeutic interventions (Fremont, 2003). Many parents do not want their children to be medicated, so this type of treatment may not be as common as behavioral and psychotherapeutic interventions. If a student is taking medication for school refusal, it is imperative that school officials continually monitor the student's educational and physical changes (Tyrrell, 2005). Consistent feedback between the student's parents and school officials will likely decrease failure and ensure the intervention to be successful.

Based on the literature reviewed, future research is necessary in the area of school refusal. Effectiveness and failure of treating school refusal needs to be documented and reported to educators. Professionals must identify the barriers to success in those interventions that fail so that the appropriate changes can be made to ensure successful treatment in the future. Evaluating current research studies in the area of school refusal will allow educators to further develop effective interventions with students. School counselors must also encourage parent participation in the intervention to create the most successful outcome.

In conclusion, although it may be time-consuming, the school counselor is advised to maintain consistent contact with the student, parents, and other school personnel regarding the individual case of school refusal. The case is a work in progress that may take some time to see results. It is important to remember that the ultimate goal of implementing an intervention for a student with school refusal is to get the child back into school with regular attendance. Each member of the team must collaborate and support the student in order for him/her to be willing to attend school on his/her own. If children with school refusal receive consistent support from their parents and school officials, their attendance problem will diminish and ensure student success both academically and socially.

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