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Anxiety and School Reluctance/Refusal

by

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Chapter I: Introduction and Statement of the Problem

Many students attempt to avoid or to reduce school attendance as a function of anxiety. This review examines the etiology of school reluctance and school refusal and investigates approaches for attenuating the concomitant difficulties arising from it. In Chapter I, school reluctance and school refusal are defined both operationally and theoretically. In addition, the behavioral and academic benefits of attenuating school refusal are hypothesized. In Chapter II, research addressing school refusal that appears in the literature of education and of psychology will be reviewed. In Chapter III, the findings from the analysis are summarized, and the implications of these findings will be described.

Introduction

A number of children experience generalized anxiety or separation anxiety when entering school or when transitioning between home and school. The behavioral symptoms may range from mild to severe. Mild symptoms may include being overly clingy to caregivers or somatization; more severe symptoms may include tantrums, panic attacks, or refusal to attend school (Mash & Wolfe, 2019). School refusal may result from both clinical phobias and anxiety disorders.

School Reluctance and Refusal

For a subset of students who experience anxieties about attending school, the behavioral episodes may escalate to verbal and physical aggression. Students with this level of anxiety will exhibit multiple maladaptive behaviors to prevent school entry or attendance. Physical, cognitive, and affective indicants of anxiety reaction manifest.

Indicants of School Related Anxiety

School reluctance and refusal yield symptoms and behaviors that consistent with anxiety responses (Mash & Wolfe, 2019). At the physical level, the student may have an increased heart rate. Breathing may be deeper and rapid. Physical sequelae such as sweating and nausea may be present. At the cognitive level, the student's thinking may be impaired; maintaining focus may be difficult. At the behavioral and affective level, the student may report subjective feelings of apprehension, may be irritable, and may show increased levels of activity (Mash & Wolfe, 2019).

Historical Overview

Anxiety disorders have been widely investigated and reported. The earliest record of anxiety dates to the fourth century BCE. Hippocrates described an individual's anxiety response to events at a celebration. References to anxiety and descriptions of the concomitant symptoms are present throughout the medical literature of the Roman error. More modern reports of anxiety begin with the psychoanalytic writings of Freud and of Jung. Finally, the roles of neurotransmitters in producing anxiety-related symptoms were widely investigated in the 1960s and the 1970s. These historical descriptions contribute to current models of anxiety in general and of school refusal in particular.

Statement of the Problem

School reluctance and refusal impair the academic and the social success of students. Chronic absenteeism resulting anxiety about school limit a student's opportunities to benefit from instruction and to interact with same age peers. Anxiety symptoms may impair cognitive producing and yield a concomitant loss in academic learning. Both memory and attention may be

adversely affected. Maladaptive behaviors including physical aggression, irritability, and tantrums may result; such behaviors may attenuate learning and may decrease opportunities for social engagement.

This review examines the relations among anxiety and school refusal. Three foci guide the analysis. First, clinical descriptions of school reluctance and refusal will be reviewed. Second, school and classroom interventions for reducing school refusal will be examined. Finally, approaches for lessening school anxiety while the student is off property will be addressed.

Rationale

Anxiety is an extremely complicated disorder and presents in many forms for students. Administration, as well as teachers, can misunderstand anxiety in schools and school refusal. This makes it difficult for students who are experiencing anxiety and refusing to go to school to complete work they miss or to participate in classroom activities. This may create even more anxiety and make it even harder to try to attend school when they feel they can try on a particular day. Addressing school refusal in a proactive manner may benefit students, teachers, and administrators.

Anxiety and school refusal can be complicated disorders for teachers to empathize with and to understand. Teachers may see anxiety and school refusal to get out of completing work or an excuse to stay home. Teachers working with students with anxiety and school refusal may be hesitant to help that student catch up with their work or excuse their absences from their class. Even though more mental health continuing education credits are required to renew teaching licenses, opinions, and refusal to accept new information cannot be forced.

When students with anxiety and school refusal are in a mainstream school and absent for so many days, administrators must get involved as it is considered truancy and reportable to the county. Even though administrators may understand the reasoning behind anxiety and school refusal, it is required by law to report absences even if they are excused at some point. When administrators are a part of due process for special education for students with anxiety and school refusal, they may need to suggest other placement like level IV or a short-term placement to see if there are other recommendations to help the student.

As a special education teacher for students with emotional and or behavioral disorders for thirteen years in level IV settings, I have seen multiple students sent to our program due to school refusal and a medical diagnosis of anxiety. Once social skills instruction is introduced and practiced throughout their day, students learn to use coping skills to be able to transition back to mainstream schools and be successful. I have a personal connection as I was a student with anxiety and school refusal and had to try to be understood and heard to get an education. The results of this analysis may assist other individuals in dealing with detrimental effects of this disorder.

Definitions

Anxiety–Intense, excessive, and persistent worry and fear about everyday situations. Fast heart rate, rapid breathing, sweating, and feeling tired may occur.

Depression–A mental condition characterized by feelings of severe despondency and dejection, typically also with feelings of inadequacy and guilt, often accompanied by lack of energy and disturbance of appetite and sleep.

Conduct Disorder–Conduct disorder is a serious behavioral and emotional disorder that can occur in children and teens. A child with this disorder may display a pattern of disruptive and violent behavior and have problems following rules.

Generalized Anxiety–Severe, ongoing anxiety that interferes with daily activities. Generalized anxiety disorder can occur at any age. The condition has symptoms similar to panic disorder, obsessive-compulsive disorder, and other types of anxiety. These symptoms include constant worry, restlessness, and trouble with concentration.

Maladaptive Behaviors–Maladaptive behaviors are those that stop you from adapting to new or difficult circumstances. They can start after a major life change, illness, or traumatic event. It could also be a habit you picked up at an early age. You can identify maladaptive behaviors and replace them with more productive ones.

Negative Reinforcement–A method that can be used to help teach specific behaviors. With negative reinforcement, something uncomfortable or otherwise unpleasant is taken away in response to a stimulus. Over time, the target behavior should increase with the expectation that the unpleasant thing will be taken away.

Tantrum–An uncontrolled outburst of anger and frustration, typically in a young child.

Truancy–The action of staying away from school without good reason; absenteeism. In the state of MN, 3 school days missed without reason results in a letter home to parents informing them of the consequences including a court appearance. Five days results in a letter to the district attorney informing them of the truancy and could result in a court appearance and a county worker for the family to assist in getting the student to school.

Oppositional Defiant Disorder–A disorder in a child marked by defiant and disobedient behavior to authority figures. The cause of oppositional defiant disorder is unknown but likely involves a combination of genetic and environmental factors. Symptoms generally begin before a child is 8 years old. They include irritable mood, argumentative and defiant behavior, aggression, and vindictiveness that last more than six months and cause significant problems at home or school.

Panic Attack–Sudden episode of intense fear or anxiety and physical symptoms, based on a perceived threat rather than imminent danger.

Performance Anxiety–Fear about one's ability to perform a specific task. People experiencing performance anxiety may worry about failing a task before it has even begun. They might believe failure will result in humiliation or rejection.

Phobias–A type of anxiety disorder defined by a persistent and excessive fear of an object or situation. Phobias typically result in a rapid onset of fear and are present for more than six months.

Positive Reinforcement–The addition of a reinforcing stimulus following a behavior that makes it more likely that the behavior will occur again in the future. When a favorable outcome, event, or reward occurs after an action, that particular response or behavior will be strengthened.

Separation Anxiety–A disorder in which a child becomes excessively anxious when separated from parents. Children are especially prone to separation anxiety during times of stress. Separation anxiety differs from normal clinginess. Children with the disorder cannot think about anything but the present fear of separation. They may have nightmares or regular physical complaints. They may be reluctant to go to school or other places.

Somatization–The production of recurrent and multiple medical symptoms with no discernible organic cause.

Chapter II: Review of the Literature

Many students attempt to avoid or to reduce school attendance as a function of anxiety. This review examines the etiology of school reluctance and school refusal and investigates approaches for attenuating the concomitant difficulties arising from it. In Chapter I, school reluctance and school refusal were defined both operationally and theoretically. In addition, the behavioral and academic benefits of attenuating school refusal were hypothesized. In Chapter II, research addressing school refusal that appears in the literature of education and of psychology is reviewed. In Chapter III, the findings from the analysis are summarized, and the implications of these findings will be described.

Scope of the Review

A number of strategies were used to identify articles and to locate fugitive research for this review. First, I completed a computational search of the databases Google Scholar and Libsearch. I used anxiety and school refusal, anxiety and school reluctance, anxiety and school avoidance, anxiety and truancy, and anxiety and attendance issues as search descriptors. The initial search generated 334,000 articles. I delimited the results of the primary search to articles that appeared after 1980.

Literature Review

In this section, I review studies addressing school refusal and reluctance. The studies are presented chronologically and topically.

The individual studies are presented. The principal findings of each study are summarized. When present, design flaws and delimitations are identified (Brandibas et al., 2004).

This study was done in a French technical secondary school to explore differential categories of school refusal. In the study 45 students were chosen that had 21 days of non-justified school absenteeism. Of the 45 students, most of which were boys (n = 44), ages 14-21 (M = 17.96, SD = 1.90) with a varied social background.

For the procedure, the sessions were done at the same time of day as biological rhythms could account for anxiety. The School Refusal Assessment Scale (SRAS) was used to assess school refusal. The State-Trait Anxiety Inventory (STAI-Y) was used to assess anxiety and the Separation Anxiety Symptom Inventory (SASI) was used to assess separation anxiety.

The study confirms the relationship between anxiety and school refusal. There is also a relationship between school refusal and separation anxiety. When attentive-getting behavior is present it is negatively linked with separation anxiety.

The SRAS should help school psychologists pinpoint which source is linked to school refusal behavior. This could potentially help professionals look at this behavior from a different perspective and offer more direct programs to deal with this phenomenon (Evans, 2000).

Chronic school refusal is usually classified under broad categories such as school phobia or truancy. However, there is a need for improved recognition and treatment of school refusal. This article hopes to extend recent efforts by showing three basic subtypes: anxiety, avoidance, and absence. This article also proposes to review findings over the past decade and treatment approaches with intentions to help practitioners in the future.

Refusing to go to school is usually thought of as frustrating or annoying behavior that is practiced by most students at least once during their K-12 school years. Any adolescent who does not skip at least once would look more suspicious than most. Due to this, students who are

considered repeat skippers or chronically absent are not immediately thought of as having a diagnosis to go with it.

Lower achievement due to school refusal can have quite an impact on families. It can create problems such as the student being held back, lower self-esteem for the child, lower grades that may affect future outlooks. Families may also have to have a parent stay at home which requires them to miss work and sometimes a parent needs to quit their job to stay home with the child. This stress can also create conflict in the home and worsen the situation.

School districts do not always report school refusal rates, but it appears as though the rates are at an incline. Ways to reduce chronic refusal have included the following subtypes, dysfunctional characteristics of the child or parents, motivation for refusal, precipitating factors, number of episodes, and severity. More recent subtypes are anxiety, avoidance, and malingering.

The functional subtypes serve two primary purposes, one which allows school refusal behavior to be viewed withing the spectrum of maladaptive behaviors and second an understanding of the interaction of behaviors that can develop. The first uses school avoidance as an example with it being a larger picture of avoidant behavior and gives a better understanding of treatment. The second classifies refusal as anxiety which gives a different treatment goal.

Treatment for school refusal can start as broad treatment such as Rapid Treatment Approach which returning them to school as quickly as possible using reassurance and reinforcement and the ignoring of physical complaints. It may also include the participation of the parents and a reduction of time spent at school. The use of medication may also be used in the treatment plan because behavior treatment is so broad of a treatment plan it may not be successful because without identifying the subtype the treatment may be less effective.

Once the subtype is identified the treatment plan can be more specific. The treatment for avoidance usually involves contingency management for example “the rule” is basically the students must be at the doctor or at school during school hours. The student cannot avoid non preferred activities and physical complaints are not ignored but are acknowledged but are marked insufficient if they miss a regular activity. The treatment plan for malingering involves contingency plan and The Rule. For The Rule to be successful, both parents and school need to up the level of supervision quickly to both parents and track each incidence of leaving school and take away access to preferred activities.

Prognosis and prevention of chronic refusal depends strongly on mutual agreement of goals by parents, school team, and other professional. The participation of the plan can decrease family stressors, and the need for contingency plans. Participation in screenings for early childhood and visits to school's pre-k also aid in the prevention of school refusal or frequent absences.

Even though the subtypes of chronic school refusal show some difficulties for assessment and treatment, it helps show school refusal as unique disorder rather than just a behavior. By identifying specific subtypes, you can develop a specific plan for students helping them become more successful and get the help they deserve (Fernandez-Sogorb et al., 2018).

The study included a random cluster sampling of 911 Spanish students ages 8-12 years old. The objectives of this study were to validate scores of the VAA-R in a Spanish child sample between ages of 8-12 years old and to further investigate the relationship between school refusal scores and anxiety profiles.

Measures used included School Refusal Assessment Scale-Revised for Children as well as Visual Analogue Scale for Anxiety-Revised. These measures were created to allow early identification of anxiety disorders produced in the school environment and are seen to provide reliable and valid scores. Informed consent was collected from parents.

The study found that high anxiety, high anxiety-school type, low anxiety, and moderate anxiety all differed significantly in all dimensions of school refusal. High anxiety profile shows greater scores of school refusal due to negative reinforcement than the other profiles. No significant differences were found regarding gender for any factor. Significant differences were found regarding age in two factors (generalized anxiety and anticipatory anxiety) but not in social anxiety. For the first time, this study replicated the 3-dimensional model proposed by Bernstein and Garfinkel (1992). The Visual Analogue Scale for the Self-Report of Anxious Symptoms has been validated in a Spanish child sample. Further investigations should be done to expand and consolidate the scientific contributions of this work (Gonzalvez et al., 2020).

This study intends to look at different school refusal behavior profiles and determine if these profiles differ from each other based on four situational factors and three response systems of school anxiety across gender. This was a study with a sample made of 1,685 Spanish adolescents (49% being females) collected by random cluster sampling. The participants ages range from 15 to 18 (Mage = 16,28; SD = 0.97) and their distribution was as follows: 411 participants with 15 years (200 boys and 211 girls), 595 participants with 16 years (310 boys and 285 girls), 474 participants with 17 years (240 boys and 234 girls) and 205 participants with 18 years (110 boys and 95 girls). No statistical age or gender differences were found (χ 2 = 1.79;

p = 0.62). With regard nationality, 88.7% were Spanish and the remaining participants had been born in other countries.

The school refusal behavior was assessed using the Spanish version of the School Refusal Assessment Scale-Revised (SRAS-R). The school anxiety was assessed using the School Anxiety Inventory (SAI).

The Vuong-Lo-Mendell-Rubin likelihood-ratio test and the bootstrap likelihood ratio test, were also used. In both cases, a p-value below 0.05 indicates that the estimated k-class model is better than the (K-1)-class model, which is therefore rejected in favor of a model with at least K classes (53). In addition, entropy was used as a criterion of the quality of class membership classification whose score closer to one was preferred. The Statistical Package for the Social Sciences (SPSS-24) was used to identify through proportion z-test the differences in each of the clusters according to gender. The effect size used to estimate the difference in sample proportions was calculated using index d Cohen (56). In this study a MANOVA was conducted to examine the differences in the school anxiety dimensions between the SRB profiles identified and across gender. The partial eta squared index (η^2_p) and post-hoc tests (Bonferroni's method) were performed to identify between which groups there were statistically significant differences. Likewise, the effect size was calculated using index d to obtain the magnitude of the differences observed (56). The index d is interpreted as follows: values between 0.20 and 0.49 indicate a low effect size, between 0.50 and 0.79 a moderate effect size, and above 0.80 a high effect size.

The relationship between the school refusal behavior profiles and school anxiety has not revealed large differences according to gender, indicating that this problem affects boys and girls in similar conditions. The profile that was the most maladaptive was the High School Refusal

Behavior since adolescents belonging to this group achieved the highest scores in all the situational factors and response systems of school anxiety. The data obtained is in line with the third hypothesis of the study. There was a higher proportion of girls in the Mixed School Refusal Behavior profile compared to boys, although the effect size was small. Students who develop school refusal behavior in these groups are characterized by internalizing problems.

However, other externalizing problems should be considered as temperament of truants in order to analyze its impact on the rest of the profiles. Not all situational factors of school anxiety are equally associated with school refusal behaviors. Therefore, reducing anxiety levels and improving coping strategies in these circumstances could help to prevent SAPs (Gonzalvez et al., 2021).

This study is to identify different affect profiles and determine whether the profiles differ from each other based on four functional conditions of school refusal behavior. Participants comprised of 1,816 Spanish adolescents aged 15-18 years (M- 16.39; SD = 1.05). The Positive and Negative Affect Schedule for Children-Short Form and the School Refusal Assessment Scale-Revised for Children were administered.

To evaluate affect the Positive and Negative Affect Schedule (PANA) was designed. It is used copiously by the scientific community and has shown adequate psychometric properties. The tool shows positive and negative affect as independent and that they be categorized at a high or low level. Based on this scale affective profiles were developed classifying people into four profiles named self-fulfilling (high positive affect and low negative affect), high affective (high positive affect and high negative affect), low affective (low positive affect and low negative affect), and self-destructive (low positive affect and high negative affect). The profiles were

based on the division of the median affect scores (Gonzalvez et al., 2021). Multiple studies have been replicated in samples of different ages and nationalities.

School refusal behavior shows up as both internalizing and externalizing behavior issues based on multiple studies. Positive and statistically significant relationships with anxiety disorders and depression have been found in adolescents whose school refusal behavior is based on the first three factors of the functional model. This fact would also be supported by the established associations between negative affect and anxiety as well as depression disorders.

The aim of this research is to identify four affective profiles based on the positive and negative affect dimensions evaluated through PANAS. LPA, unlike cluster analysis, is a method that fits a statistical model to the data and classifies each person in the most likely group based on their responses to a set of variables. It is a tool that focuses on the similarities rather than the relationships between variables and is considered a more accurate technique\than cluster analysis (Berlin et al., 2014).

The study sample consisted of 1,816 Spanish adolescents (51.3%\boys) whose ages ranged from 15 to 18 years (M = 16.39, SD = 1.05). All participants were typically developing adolescents with no psychological, behavioral, or linguistic problems. The chi-square test of homogeneity in the frequency distribution revealed the absence of statistically significant differences between the sex and age groups.

The PANAS-C-Short Form was used in this study and is a self-report measure for children and adolescents between 6 and 18 years that assesses positive and negative affect. It is a 10-item questionnaire made up of two subscales measuring the positive (joyful, lively, happy,

energetic, and proud) and negative (depressed, angry, fearful/scared, afraid, and sad). The Spanish version of this report developed by Gonzalvez et al. (2018) was used in this study.

The study involved 16 public and private high schools located in Alicante and Murcia, Spain, which were asked to participate by the University of Alicante (code of. UA-2017-09-05) in a series of interviews with their principals about the aims of the study. Half of the subjects filled out the measure of affect and then the scale on school refusal behavior, while the other half filled out questionnaires in reverse order.

A series of LPA models were applied to identify the most adequate class solution for the two-factor conceptualization of affectivity. Correlations between the positive and negative affect and the four conditions of school refusal behavior were tested using Pearson's product–moment correlation coefficient. The classification accuracy of each solution was examined using seven fit statistics criteria to evaluate the models.

The positive and negative affect were largely statistically significant and weakly related to the four dimensions of school refusal behavior in the SRAS-R-C study. The four school refusal behavior dimensions positively correlated with the Positive Affect, but the tangible rewards dimension negatively correlated with it. The negative reinforcement conditions, which are the first two factors of the.

The self-destructive profile showed. The highest average scores in the first three factors of SRAS-RC, whereas the high affective profile reached the highest average score in the fourth factor. The largest effect sizes have been found by comparing the self-fulfilling, self- destructive, and high affective profiles with the low affective profile. Differences with a large effect size have also been found between the low positive profile and the self-destructive profile.

Overall, the pattern exists that the low positive affect does have an effect on school refusal behaviors and has a correlation with anxiety and depression (Gonzalvez et al., 1981).

The purpose of this study is to develop profiles of school refusal behavior in a novel cultural context, allowing for comparisons with other cultures. The study's hypothesis was that identification of distinct groups of students who refused to attend school was expected, consistent with the functional model. The mixed school refusal on behavior group is expected to be more maladaptive, with higher scores on anticipatory, school, and generalized anxiety.

The study recruited participants through a multi-stage random cluster sampling methodology in which five distinct geographical areas within the province of Alicante, Spain was chosen. Each geographic area had between one and three schools participate, for a total of sixteen public and private schools. Specifically, four classrooms were randomly selected from each school, one from each Academic Year from third to sixth grade of primary education, with approximately 92% participation. The final sample consisted of 1113 students (52.3%) who were male and aged between 8 and 11 years (M equals 9.53; capital SD = 1.10).

Measures: The SRAS-R is a self-report instrument that assesses four distinct motivational states. The Spanish version of the SRAS-R developed by Gonzalves et al. (2018) was used in this study. It consists of 18 items scored on a seven-point Likert scale from 0 to 6 (never to always).

The VARR is a self-report measure composed of an 11-item battery that serves as a visual analogy for quantifying the level of anxiety elicited by various situations. This three-factor solution was developed to assess anxiety in children and adolescents with school refusal behavior.

An analysis of variance, or ANOVA, was used to compare the school refusal behavior profiles identified in the anxiety components.

Additionally, the magnitude of observed differences is determined by calculating the effect size using the d-index.

The first group consisted of 499 subjects with low ANA, ESE, and PAS scores and moderately low PTR scores. This group was dubbed the non-attenders. The second group consisted of 319 subjects with high PAS and PTR scores and moderate ANA and ESE scores. Positive reinforcement refers to this group as school refusers. The third group, dubbed school refusers through negative reinforcement, consisted of 154 participants who scored highly on the ANA and ESE dimensions but scored moderately on the PAS and PTR dimensions. Finally, the fourth cluster included 143 participants who scored highly on the ANA, ESE, and PAS dimensions but scored moderately on the PTR dimension. By way of mixed reinforcement, this group was dubbed School refusers.

Four school refusal behavior groups were identified based on the findings, consisting of students who attend class regularly but have varying scores and motivating factors for school or refusal behavior: non-school refusal, positive reinforcement, school refusal, negative reinforcement refusal, and mixed school refusal. Thus, the work's initial hypothesis is confirmed (Gonzalvez et al., 2018).

In this study they examined school attendance difficulties with school refusal behavior. They looked at both negative and positive reinforcement as functions of the behavior. The study included 1, 582 Ecuadorian adolescents (964 males/618 females) recruited by random cluster sampling. Participants were aged 12-18 years.

Measures included administering the School Refusal Assessment Scale-Revised (SRAS) as well as the Depression, Anxiety, and Stress Scale (DASS) to the participants. Written consent was obtained from parents/legal guardians. The SRAS-R looks at four components which include I. Avoidance of Negative Affectivity, II. Escape from Social and/or Evaluative situations, III. Pursuit Attention, and IV. Pursuit Tangible Reinforcement).

Statistically significant differences were found among school refusal behavior on all three variables. Three school refusal behavior profiles included non-school refusal behavior, tangible reinforcement, and multiple reinforcements. Non-school refusal behavior was the highest number of students but the second highest included tangible reinforcement. The non-school refusal behavior group had the lowest scores in the three emotional dimensions (anxiety, depression, stress) whereas the multiple reinforcement group had higher scores on all emotional states. The tangible reinforcement group was the second most maladaptive group.

Other studies have pointed to a relationship between high scores in the first three factors of the SRAS-R and internalizing problems, but this study contrasted by showing high scores in the fourth factor (Pursuit Tangible Reinforcement) as well which as previously been more associated with externalizing problems such as oppositional disorders and conduct disorders (Heyne et al., 2011).

In a non-randomized trial, this study examined the efficacy of developmentally sensitive CBT. The treatment focuses on anxiety-related school refusal. Treatment is hypothesized to be associated with an increase in school attendance. Reduced school-related fear and anxiety are the outcome variables. Additionally, the study anticipated a decrease in adolescent depression and an

increase in adolescent and parent self-efficacy. The new treatment's acceptability was evaluated from the perspectives of adolescents, parents, and school personnel.

Clinicians or MA-level graduates recruited parents to participate in a telephone screening. Families were informed about the study and asked to consent.

The primary outcome variables were school attendance, school-related fear and anxiety, and school-related fear and anxiety. School attendance was recorded twice daily, and the percentage of time spent at school for the ten school days preceding the assessment was calculated.

School-related fear was assessed using the school-related fear thermometer and 12 school-related items from the Fear Survey Schedule for Children-Revised. The Multidimensional Anxiety Scale for Children and Adolescents (MASC/MASC-P) and the Anxiety Disorders Interview Schedule for Children and Adolescents (ADIS-C/P), a semi-structured diagnostic interview administered separately to parents and adolescents, were used to assess anxiety. The Children's Depression Inventory, the Youth Self Report, and the Child Behavior Checklist were used to assess self-efficacy.

The treatment was dubbed "the @school program" and was administered one-on-one rather than in a group setting. It consisted of modules that incorporated both existing and new treatment elements from the original practitioner guide. Typically, the @school program consisted of 10 to 14 individual sessions and 10 to 14 sessions with their parents.

The findings indicated that significant increases in school attendance were observed over time. The repeated contractures revealed that attendance levels increased significantly between pre- and post-treatment but did not change significantly between post- and follow-up. Nine of the

study's twenty adolescents attended school at least 80% of the time, while the remaining nine attended 50% or less of the time.

During pre-treatment to follow up there was significant difference however post-treatment showed Fear of school remained constant, self-reported anxiety significantly decreased, and self-efficacy remained constant.

This was an uncontrolled study with a small sample size and ethnic homogeneity. It is recommended that this intervention be evaluated in a larger and more diverse sample, as well as in comparison to the original CBT, which was not designed as a developmentally sensitive treatment for school refusal (Hsia, 1984).

This study aims to identify different school refusal behaviors and determine if they differ from each other or not. The three anxiety profiles they examine are anticipatory anxiety, school-based performance anxiety, and generalized anxiety. The study participants were Spanish children aged 8-11 years of age. The two assessments used were the School Refusal Assessment Scale-Revised and the Visual Analogue Scale for Anxiety-Revised. The analysis showed four school refusal behavior profiles: Non-School refusal, School Refusal by Positive Reinforcement, School Refusal by Negative Reinforcement, and School Refusal by Mixed Reinforcement. The group with the highest mean was the Mixed Reinforcement group. Overall, the control of anxiety may be an important goal of preventative interventions (Hughes et al., 2010).

This study examined the use of ER strategies in a sample of clinic-referred children and adolescents exhibiting school refusal. Based on previous anxiety research, it was hypothesized that the school refusal sample would report less use of healthy ER strategies than a nonclinical age- and sex-matched sample. To be more precise, it was hypothesized that the school refusal

sample would report less cognitive reappraisal and more expressive suppression than the nonclinical sample.

Twenty-one participants (52% male; age range: 10.7-14.6, X = 13.4 years, SD = 0.9) were recruited from a Melbourne School Refusal Clinic. Children were eligible for intervention if their attendance at school was less than 50% in the preceding 4 weeks. According to the Anxiety Disorders Interview Schedule, the participants had a primary diagnosis of social phobia, generalized anxiety disorder, separation anxiety disorder, or panic disorder.

The Emotion Regulation Questionnaire for Children and Adolescents (ERQ-CA) was used in this study. It contains ten items that assess the ER strategy of cognitive reappraisal and expressive suppression. The RCMAS is a 28-item questionnaire that assesses anxiety symptoms. While the RCMAS does not assess specific anxiety disorders, some have expressed concern about its ability to distinguish anxiety disorders from other psychiatric disorders. The CDI, a 27-item self-report measure of depressive symptomatology for children aged 7 to 17, was also used. Finally, the Anxiety Disorders Interview Schedule for the DSM-IV (ASIS-IV) is a semi-structured interview schedule for assessing a variety of childhood anxiety, mood, and behavior disorders that are included in the DSM-IV.

The most frequently diagnosed anxiety disorder was generalized anxiety disorder, followed by social phobia, and separation anxiety disorder. Seventeen cases had more than one diagnosis, most frequently mood disorders.

In conclusion, the fact that school-refusing children are less likely to regulate their emotions through cognitive reappraisal may reflect anxious children's proclivity for fixed,

persistent, and skewed threat-related interpretations of situations, a proclivity that is exacerbated by a lack of exposure to appropriate interpretations (Kearney & Albano, 2004).

This study assessed 143 youth with primary school refusal behavior. The sample was 62.9% male with a mean age of 11.60 years. Ages ranged from 5-7 years SD = 3.17. The measures used were diagnostic interview, Anxiety Disorders Interview Schedule for Children-Child and Parent Versions (ADIS-C/P) to obtain DSM-IV diagnosis.

The results indicated that significant heterogeneity in diagnoses marks this population. It shows that anxiety-related diagnoses are associated more with negatively reinforced school refusal behavior. It mentions that separation anxiety disorder was associated more with attention-seeking behavior, oppositional defiant disorder and conduct disorder were associated with the pursuit of tangible reinforcement outside of school. Overall, this supports a correlation between anxiety and school refusal. The School Refusal Assessment Scale (SRAS) was administered to children and parents as well.

For the results, separation anxiety disorder was the most prominent diagnosis, although many youths met criteria for other anxiety, mood, and disruptive behaviors as well. In one third of cases, there was a lack of diagnosis. Combined report distribution shows significant difference with respect to separation anxiety disorder ($p = .0001$), oppositional defiant disorder ($p = .016$), major depression ($p = .013$), conduct disorder ($p = .029$), presence of any anxiety disorder ($p = .001$), and presence of oppositional defiance disorder or conduct disorder ($p = .002$). Trends were found with generalized anxiety disorder ($p = .088$) and no diagnosis ($p = .080$). Overall, separation anxiety disorder was much more prevalent in the attention seeking group. Diagnosis of anxiety disorders tended to concentrate in the negative reinforcement functions.

With respect for age, children tended to be younger if they refused school for attention. Children tended to be older if they refused school to escape aversive social situations or to pursue tangible reinforcement outside of school. Overall, children in general tended to have the most severe diagnoses if they refused school to avoid stimuli that provoked negative affectivity. This study is one of a few to examine youth with general school refusal behavior and not just school aged children with anxiety-based absenteeism. Consistent with previous studies using smaller samples, internalizing disorders tended to be associated more with negatively reinforced school refusal behavior, separation anxiety disorder was associated more with attention-seeking behavior, and oppositional defiant disorder and conduct disorder were associated more with pursuit of tangible reinforcement outside school. Generalized anxiety disorder and social anxiety disorder did not clearly differentiate the negative reinforcement functions as one might expect.

This study confirms that the sole reliance on diagnosis to organize youth with school refusal behavior is a challenging task. A better strategy might be to consider both the forms and the functions of children's refusal behavior when developing taxonomic systems for this population.

The present study supports certain directions that clinicians may wish to take during their evaluation process. A particularly instructive observation is to examine the child and family during their morning routine to note patterns of avoidance and negative affectivity. Clinicians are encouraged to look beyond the traditional notion of truancy and focus more on the child's behaviors and enticements outside of school as well as on the family's problem-solving abilities and motivation to change the current situation.

More information is needed on specific diagnostic patterns that are associated with functions of school refusal behavior. A greater mixture of functional and diagnostic approaches is needed in publications regarding school refusal behavior to maximize the utility of the information for clinicians (King et al., 1998).

This study reported on the efficacy of a cognitive-behavioral intervention program given to students with anxiety disorders exhibiting school refusal behaviors. The treatment period was about 4 weeks. Twenty children and adolescents (7 girls and 13 boys) included in this study had been referred to the School Refusal Clinic at the Centre for Developmental Psychiatry at Monash Medical Centre. The ages ranged from 6-14 years had to meet criteria which included severe emotional upset when faced with going to school, persistent difficulties attending school, parental knowledge of them being home when they should be at school, and absence of antisocial characteristics. School attendance issues were prevalent for all children. All the children had a primary anxiety disorder diagnosis. The diagnoses could include adjustment disorder with anxious mood, anxiety disorder NOS, separation anxiety disorder, over-anxious disorder, and obsessive-compulsive disorder. Ten of the children had a comorbid diagnosis. Child therapy as well as parent/teacher training were utilized.

Measures included school attendance records, child and parent structured diagnostic interviews, self-report measures, a fear thermometer that ranged from 0-100 in accordance with the children’s distress associated with school attendance, the Self-Efficacy Questionnaire for School Situations, parent and teacher measures, and clinician rating using the Global Assessment of Functioning Scale.

Children underwent significant changes from pretreatment to posttreatment in nearly all measures. School attendance improved from 46.50%-86.75%, respectively. There was an increase in confidence to cope with anxiety provoking situations as well as a reduction in negative effects. Internalizing problems and global functioning showed similar patterns of improvement Significant changes in all measures indicate the maintenance of treatment goals. This study also found fewer children met diagnostic criteria for an anxiety disorder following treatment (85% decrease). This suggests that brief cognitive-behavioral intervention is an effective treatment for anxiety disorders associated with school refusal. The study also made note that both child therapy and parent/teacher training were essential (McShane et al., 2001).

This study focuses on school refusal from the years between 1194 and 1998 at the Rivendell Unit, which is a university affiliated, child and adolescent psychiatric facility in Sydney, Australia that provides inpatient and outpatient services. It was hypothesized that: (1) young people with school refusal would mainly have anxiety and depressive disorders; (2) those with school refusal admitted as inpatients would have a more severe condition, for example would show greater functional impairment on Global Assessment of Functioning (GAF) and greater comorbidity. The subjects were 192 young persons (10-17 years), assessed or treated for school refusal. School refusal problems were identified by reviewing all the medical records of the unit between January 1996 and December 1998. Individuals were included in the study if (1) the parent gave a positive response (a rating of 1 or 2) to the Child Behavior Checklist (CBCL) item ‘fears school’ [20] at initial assessment, and (2) school refusal was corroborated by the parents (who identified school refusal as the presenting problem in the unit’s initial

questionnaire) or by the referring agent on the referral form. On initial assessment, subjects diagnosed with psychosis, conduct disorder or obsessive-compulsive disorder were excluded.

School refusal patients who were presented to Rivendell between 1994 and 1998 were 7% of all patients assessed at the unit (n = 2561). The mean age at assessment was 14.2 years (SD = 1.3, range = 10-17 years). Refusal to attend school generally began in the first or second year of high school; the mean age of onset of academic difficulties was 12.3 years. A little more than half of the patients lived in an intact (dual parent) family; one-third lived with a single parent; and physical illness was reported in about half the patients. Children who were admitted as inpatients for school attendance problems had reduced total competency (mean 10.9, SD = 3.3) and a moderately depressed mood at the time of admission.

Similar proportions of the patients' fathers and mothers completed the equivalent of 6 years of secondary schooling. Mean GAF and CES-DC on assessment were 54 (out of 100) and 25 (out 60) out of 100, respectively, suggesting that these adolescents were significantly impaired. Clinical diagnoses of anxiety, mood and disruptive behavior disorders were very frequent in the sample. Inpatients had significantly more comorbid diagnoses than the rest (chi-squared [4,192] = 20.25, $p < 0.001$). There were no differences between inpatients and the rest on CES-DC, GAF ratings or CBCL scores.

Our study also revealed a high prevalence of disruptive behavior disorders (apart from conduct disorder) which has not been highlighted previously. Treatment for young people with school refusal is the focus of a companion\paper on patient outcomes.

Inpatients with school refusal were not more impaired or had more severe symptoms than those who were not admitted for treatment. Family or peer conflict and academic difficulties

were the major stressors associated with the onset of the problem. Young people with mood disorder (dysthymia) or with comorbid diagnoses were more likely to be admitted for inpatient treatment. The study has several limitations, including that the design was retrospective and there was no control group. Anxiety and depressive disorders are generally found in these patients, and duration of symptoms prior to presentation (mostly 2 years or under) is in keeping with previous research [9–17] (Sibeoni et al., 2017).

Anxiety-based school refusal in school-age children is complex and challenging to treat. This disorder also has serious academic and psychiatric repercussions. The objective of this qualitative study was to explore how teens experiencing this disorder received psychiatric treatment. This study took place in three adolescent psychiatry departments in France and consisted of semi-structured interviews with the adolescents receiving care and their parents. Each center offered similar care, had a outpatient unit, a day-hospital, and an impatient unit. Individual as well as therapy groups were used.

This study included 20 adolescents aged 12-18 and 21 parents for a total of 41 patients. The adolescents spoke fluent French, had anxiety-based school refusal which led to a disconnection to school (at least one month of not attending school), and resulted in at least 6 months prior treatment. The subjects needed to also be psychologically healthy enough to participate in the interview. The patients needed to have a diagnosis of anxiety disorder based on the DSM-5 which includes generalized anxiety, separation anxiety, social phobia, and panic disorders. Half of the subjects also had depressive disorder. The patients could not have a conduct disorder and parents needed to have knowledge of where students are when they are not attending school.

The interviews were conducted by the same researcher, lasted anywhere from 60 to 90 minutes, and lasted from September 2014-March 2015. Thematic analysis was used with the goal of identifying the similarities and differences that occurred in order to discern the patterns and integrate any novel issues that emerged.

Two themes emerged from the analysis: (1) the goals of psychiatric care with two sub-themes, “self-transformation” and problem-solving; and (2) the therapeutic levers identified as effective with two sub-themes: time, space, and relationships. When it came to goals of care, the adolescents focused more on the internal issues and the parents focused more on the external goals. Parents saw return and recovery as the same whereas adolescents’ internal goals may need additional time to be achieved. Some important therapeutic components that came out of the study included the value of time, relationships, and space.

Chapter III: Summary of Findings

Summary

School reluctance and refusal impair the academic and the social success of students. Chronic absenteeism resulting in anxiety about school limits a student’s opportunities to benefit from instruction and to interact with peers of the same age.

After reviewing the findings, I am satisfied with the results being multifaceted related. I think that many schools across the globe are reviewing school refusal and why it is occurring. My research shows that there is a relationship between anxiety and school refusal. Some of the reviews state this as negative reinforcement and that positive reinforcement is able to help decrease the number of students refusing to go to school due to anxiety.

In most cases, school refusers had not only anxiety but other mood and disruptive disorders. Typically, anxiety-related diagnosis were associated more with negatively reinforced school behavior; separation anxiety disorder was associated more with attention-seeking behavior; and oppositional defiant disorder and conduct disorder were associated more with pursuit of tangible reinforcement outside of school. The mixed reinforcement group was the most maladaptive profile since it obtained the highest mean scores on three dimensions and the total score of the Visual Analogue Scale for Anxiety-Revised (VAA-R). In contrast, non-school refusal and positive reinforcement groups revealed the lowest scores in eleven of the anxiety dimensions. For adolescents with severe or persistent anxiety-based school refusal, self-transformation and another relationship with school is possible within psychiatric care and in a psychiatric space.

No latent mean differences were found across settings but did occur through age in AA and GA factors. Cluster analysis identified four child anxiety profiles: High Anxiety, High Anxiety School-type, Low anxiety, and moderate anxiety, which differed significantly in all dimensions of school refusal.

Associations that are found also are stated to be useful to educational as well as clinical interventions to help promote school adjustment.

Implications

Implications in the educational setting as it relates to anxiety and school refusal/ reluctance would be to have more interventions such as school-wide social-emotional learning classes, more involvement of the school counselors, and more school therapists, as CBT was shown to work in multiple cases, involved to help students and parents with school refusal/reluctance. These interventions would be schoolwide and not just through special education teachers. These interventions would also need to be used early on when the number of absences becomes noticeable and not once the student had missed school so much that catching up becomes another piece of the anxiety puzzle.

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