School Absenteeism and School Refusal Behavior: A Review and Suggestions for School-Based Health Professionals
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ABSTRACT: School absenteeism and school refusal behavior are particularly difficult problems that school health professionals often face. Unfortunately, few recommendations are available to such professionals about how to address this population. In this article, we (1) outline the major characteristics of school absenteeism and school refusal behavior, (2) review school-based health programs that have been designed in part to reduce absenteeism, and (3) provide suggestions for school health professionals regarding individual youths with school refusal behavior. (J Sch Health. 2006;76(1):3-7)

A perplexing and potentially devastating set of problems faced by many school-based health professionals involves student absenteeism and school refusal behavior. School absenteeism refers to absence from school for any legitimate or illegitimate reason. Regarding illegitimate school absenteeism, school refusal behavior refers to a child-motivated refusal to attend school and/or difficulty remaining in classes for an entire day.1

Although school-based health professionals are commonly confronted with youths who miss school or who attempt to miss school, few recommendations are available in the literature to guide their assessment and treatment of this population. The purposes of this article are thus to (1) outline the major characteristics of school absenteeism and school refusal behavior, (2) review school-based health programs that have been designed in part to reduce absenteeism, and (3) provide suggestions for school health professionals regarding individual youths with school refusal behavior.

SCHOOL ABSENTEEISM

According to the National Center for Health Statistics, only 27.5% of youths aged 5-17 years in the United States in 2003 had missed no school days due to injury or illness.2 Instead, many had missed 1-2 days (26.8%), 3-5 days (28.1%), 6-10 days (11.3%), or 11+ days (5.4%). In addition, 0.9% of youths did not attend school at all. Rates of severe absenteeism (11+ days) tended to be higher among adolescents than children (6.6% vs 4.5%), among poor families than nonpoor families (8.2% vs 4.9%), and among youths with fair/poor health than youths with excellent/very good health (27.2% vs 4.4%). For more detail and for updated figures over time, refer to the summary health statistics for US children at www.cdc.gov/nchs/nhis.htm.

Common health-related reasons for legitimate absenteeism include general illness, gastrointestinal distress, influenza, allergic rhinitis, respiratory illness, dysmenorrhea, diabetes, head louse infestation, orodental disease, and chronic pain and illnesses such as cancer, Crohn’s disease, dyspepsia, headache, hemophilia, irritable bowel syndrome, and chronic fatigue syndrome. In addition, conditions that aggravate these health problems have also been linked to absenteeism, most notably air pollution and carbon and nitrogen dioxide. Asthma, however, is the largest medical contributor to absenteeism.3 Asthma affects 13% of youths younger than 18 years, and youths with asthma miss 3 times more school days than their peers without asthma.2 Asthma and absenteeism are closely linked not only in the United States but also worldwide.4

School absenteeism may be due to many other legitimate reasons as well. Examples include observance of religious holidays, important family functions such as a funeral, poor weather conditions, and approved exemptions for college attendance or work-study programs. A large majority of school days missed, perhaps as many as 80%, are due to these legitimate reasons.5 However, many youths deliberately miss school or experience substantial distress regarding school that prompts attempts to miss school. Such behavior is a main focus of this article.

SCHOOL REFUSAL BEHAVIOR

School refusal behavior refers to illegitimate absenteeism or, more specifically, to child-motivated refusal to attend school or difficulty attending classes or remaining in school for an entire day. The behavior is often manifested by a spectrum of absenteeism that includes complete absence for long periods of time, partial absences due to skipping classes or missing part of a school day, chronic tardiness, and sporadic or full-time school attendance marked by substantial dread about going to school and pleas to parents and others to remain home from school.6 Thus, school refusal behavior includes youths who are actually missing school as well as those who wish to miss school but who have not yet reached this goal.

The percentage of youths who refuse to attend school is difficult to pinpoint, though 5-28% are likely to display school refusal behavior at some point in their lives.5 Many
absences are due to skipping classes or missing specific times of the school day, particularly after lunch. According to the National Center for Education Statistics, skipping time from school accounted for 26.1% of days missed from school among 12th graders. These numbers were 15.6% for 10th graders and 9.0% for 8th graders (see nces.ed.gov/programs/coe for more detail and for updated figures over time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time). In addition, tardiness to school may affect 4.4-9.5% of youths and intense distress during school attendance time).

School refusal behavior is typically marked by substantial symptom heterogeneity, meaning that a complex clinical picture of internalizing and externalizing behavior problems is often seen. Youths who refuse to go to school, for example, often show internalizing problems such as depression and suicidal behavior, fatigue, and somatic complaints. Common somatic complaints include stomachaches, abdominal pain, headaches, nausea, diarrhea, and shortness of breath. In addition, youths with school refusal behavior often show externalizing behavior problems such as defiance and noncompliance, running away from school or home, verbal and physical aggression, temper tantrums, and clinging.

The most common diagnoses for youths with school refusal behavior include separation anxiety disorder (22.4%), generalized anxiety disorder (10.5%), oppositional defiant disorder (8.4%), depression (4.9%), specific phobia (4.2%), social anxiety disorder (3.5%), and conduct disorder (2.8%), among several others. These data support the idea that many youths refuse school because of substantial distress, though others certainly refuse school for attention or to pursue tangible reinforcers, such as time with friends, riding a bicycle, or sleeping late, outside of school.

School refusal behavior can be a potentially devastating problem for families and typically leads to severe short-term and long-term consequences. Key short-term consequences include incomplete schoolwork and academic failure, alienation from peers, legal and financial difficulty, missed time from work, and substantial family and parental school official conflict. Key long-term consequences include potential school dropout, delinquency, economic deprivation, later occupational and marital problems, and need for further psychiatric assistance in adulthood.

The assessment and treatment of school refusal behavior is thus an imperative task for psychologists, educators, and health professionals. Unfortunately, progress in this area has been beset by a lack of consensus about how to define and address this population. For example, numerous terms have been bandied about to describe illegitimate and problematic absenteeism, including school phobia, truancy, school refusal, and separation anxiety. We prefer the term “school refusal behavior,” however, because it encompasses all youths who refuse to attend school.

**SCHOOL-BASED HEALTH PROFESSIONAL INTERVENTIONS FOR ABSENTEEISM**

Various programs for school-based health professionals have been proposed to help reduce student absenteeism due to illness. A common one involves asthma management. Evidence indicates that school-based management of asthma is related to youths who are more likely to bring asthma medication and peak flow meters to school and who have less severe asthma symptoms over time. Case management consisted of contacting parents and physicians, educating family members about asthma, and engaging in home visits. In addition, others have found that school-based education about asthma, student access to and training in peak flow meters, and provision of an emergency call number reduced missed school days and unscheduled physician visits by two thirds. Severity of asthma symptoms during the day and night was reduced as well (62% and 34%, respectively).

Others have developed school-based clinics in an attempt to quell asthma and school absenteeism. Some have found, for example, that a more active, clinic-based approach is effective for increasing knowledge of asthma but has little effect on symptoms, peak flow rate, or school attendance. Others have found, however, that school absenteeism due to asthma and other illness is less likely if students have access to a full-time, as opposed to a part-time, nurse. A greater school nurse to student ratio is also associated with less asthma, as is greater school nurse support.

Other health-based programs have been designed to reduce the spread of communicable disease within schools. For example, some have found that children who used a hand sanitizer at school were substantially less likely to miss school compared to those who did not. In addition, educating students about the importance of handwashing has been shown to reduce absenteeism.

Still, other health-based programs have been designed to address stressful circumstances and mental health needs that can lead to excessive absenteeism. For example, some researchers established a support group for youths with problems attending school. The group met with a school nurse once per week for 5 weeks for an hour per session. General discussions were held about illness, weekly attendance goals, depression, and likes and dislikes about school. Related programs have been discussed to ease anxiety, depression, substance abuse, and stressful life events. Other programs have been discussed regarding safety for homosexual students, teenage pregnancy, bullying, and general psychological problems as a child enters adolescence.

Although school-based nursing programs have been introduced to help reduce school absenteeism, much of the literature continues to surround ancillary topics such as asthma and not absenteeism directly. As such, school-based health professionals may be unsure about the best strategies for addressing a particular youth with school refusal behavior. In the sections that follow, we summarize studies that have been conducted to reduce school refusal behavior in youths and discuss specific responses.
that school-based health professionals can utilize when faced with a particular child with this behavior.

GENERAL CLINICAL INTERVENTIONS FOR SCHOOL REFUSAL BEHAVIOR

General clinical interventions for youths with school refusal behavior have focused mainly on cognitive-behavioral strategies to increase attendance and reduce distress. For youths who are anxious about attending school, common treatment strategies include child-based education about anxiety and school refusal behavior (avoidance), relaxation training, breathing retraining, cognitive restructuring, and exposure-based practices designed to gradually reintroduce a child to his or her regular school setting. Several studies have found this approach to be quite useful for youths with anxiety-based school absenteeism.22-25 Medications have also been utilized for these youths, but the use of anxiolytics and antidepressants appears to have only limited effects.26

For youths who refuse school for attention from significant others, common treatment strategies include parent-based contingency management, establishment of house rules with rewards and disincentives, structured routines in the morning and evening, alteration of parent commands toward brevity and clarity, reduction of excessive reassurance-seeking behavior, and, occasionally, forced school attendance. For youths who refuse school for tangible reinforcement outside of school, common treatment strategies include family-based contingency contracting, communication skills training, and peer refusal skills training (to rebuff offers from peers to miss school). Schedules to reintroduce a child to school are also incorporated in these approaches.

These strategies have been shown to be effective when specifically targeted toward certain youths with school refusal behavior.23,27 Detailed procedures for all of these treatment techniques are available and may be modified by school-based health professionals for use with groups or individuals with school refusal behavior. In addition, suggestions for expanding these techniques to account for broader contextual variables such as family dysfunction and comorbidity have been provided.9,28

SUGGESTIONS FOR SCHOOL-BASED HEALTH PROFESSIONALS

Having outlined the major characteristics and general clinical interventions for school refusal behavior, we turn next to specific suggestions for school-based health professionals who are confronted with a particular child with school refusal behavior. In cases where a child is missing school for extended periods of time, visits to the school nurse’s office will obviously be limited. Instead, school-based health professionals are much more likely to encounter youths with school refusal behavior who (1) are anxious in the morning about school or parental separation, (2) engage in misbehaviors during the school day to visit the school nurse’s office to avoid or escape the classroom or to be sent home, and/or (3) display high levels of somatic complaints because of school attendance. We provide suggestions for each of these groups.

Youths Anxious in the Morning About School or Separation From Parents

Youths with school refusal behavior who are anxious about school or separation from parents will often resist school in the morning before classes begin. Such behavior is often manifested by temper tantrums, crying, refusal to move, running away from the school building, and withdrawn behavior. Here, a school health professional may be called upon to address a high-intensity situation. If the situation is new, a key rule of thumb that we have successfully used in our clinic is to allow a child to remain where he or she is without permitting regression (if possible). For example, if a child has successfully entered the school’s lobby, it would be preferable for him or her to remain there, even for the full day, than allowing him or her to return home. Similarly, if a child has successfully entered the school library, it would be preferable for him or her to remain there, even for the full day, than allowing him or her to retreat to the lobby.

In addition, having parents leave the school setting during this process is often helpful. In some cases, however, we have asked parents to sit in the car with a child in the school parking lot or stand with him or her on the playground for as long as possible during the day. During this process, the parent or school-based health professional may encourage attendance at regular intervals, such as every 30 minutes.

Obviously, this approach must be considered within the scope of any pertinent school regulations, and the safety of the child may require school police intervention, such as when a child flees school. However, keeping a child where he or she is does not reward “successful” avoidance or escape behavior and serves as an exposure-based practice so that anxiety declines during the course of the day. In other words, the child will eventually habituate to his or her surroundings and may be more likely to enter school and class. A child who enters school at 10:30 am will likely be easier to address in the long run than a child who “successfully” missed the entire day. This process can be supplemented by strategies to help a child control physical symptoms of anxiety, perhaps via relaxation training or breathing retraining.9

Youths who are anxious about school or parental separation are likely to seek excessive amounts of reassurance from school-based health professionals and other officials as well. In these cases, a good rule of thumb is to answer a child’s question once (What if something happens to my mom?) and then ignore subsequent repetitions or versions of the question for at least 1 hour. This serves to provide accurate information to the child but does not reward inappropriate behavior. In addition, we have sometimes allowed youths to contact their parents during the day as a reward for school attendance and appropriate classroom behavior, and this may be done in selected cases.

Youths who are highly anxious about school may also be on medication for their condition. In these cases, school-based health professionals are encouraged to identify the type and dosage level of the medication, consult with the child’s physician and parents, and research the likely efficacy and side effects of the medication. As mentioned earlier, medication for youths with school refusal behavior is not generally effective but can be in cases of severe anxiety or depression.
Youths With School Refusal Behavior
Who Are Sent to the Office

School-based health professionals may also encounter youths with school refusal behavior who deliberately attempt to be sent to their office. Often this comes about following refusal to participate in class due to somatic complaints, excessive anxiety, or more severe problems. Once a child reaches the nurse’s office, and school refusal behavior is suspected, we recommend conducting a brief assessment to determine the function of the child’s behavior.

A good child self-report instrument is the School Refusal Assessment Scale—Revised, which measures whether youths refuse school to (1) avoid school-based stimuli that provoke symptoms of anxiety and depression, (2) escape aversive social and/or evaluative situations, (3) pursue attention from significant others, and/or (4) pursue tangible reinforcement outside school.29 Once this function is identified, then specific procedures to address the situation can be implemented.9,28 In addition, a child should be asked about what triggered his or her visit to the office, and what he or she believes should happen next (I should be sent home).

If a child is attempting to be sent home, then keeping the child in school is generally the best option. Sending a child home will reinforce avoidant behavior and increase the likelihood of misbehavior in the future. Instead, school-based health professionals are encouraged to ease physical symptoms of anxiety, intermittently encourage return to class, reward successful attempts to resume classroom attendance, and consult with parents and other school officials as necessary to develop a long-term plan for such behavior. Often this approach can include a specific 504 Plan to accommodate short-term respite from the classroom with the eventual goal of full-time attendance.

Youth With Somatic Complaints

As mentioned earlier, youths with school refusal behavior often display severe somatic complaints, especially headaches, stomachaches, and other problems that are not easily measured. In our experience, we have found that youths with school refusal behavior often have (1) intense physical symptoms as a result of their anxiety, (2) less-intense physical symptoms that are exaggerated for attention or escape from school, or (3) no physical symptoms despite a child’s claims to the contrary. In all cases where a child claims the presence of physical symptoms, referral for a full medical examination is recommended.

If a child has a true medical condition, such as a stomach ulcer, then standard procedures to accommodate such a child can be followed. If no obvious medical condition is evident, then we recommend designing a set schedule of classroom attendance that gradually increases in intensity each week. For example, a child may be asked to attend 1 additional hour or 1 additional class per week until full-time attendance is achieved. Or, a child may be asked to spend his or her day in the school library prior to gradual reintroduction to class. During this process, procedures to reduce physical symptoms of anxiety should be pursued. In addition, classroom attendance despite the presence of physical symptoms of anxiety should be actively rewarded in some way.

FINAL COMMENTS

Addressing youths with school refusal behavior can be a delicate and frustrating experience for school-based health professionals. We recommend that any assessment and treatment process be borne not by a school health professional alone but by a multidisciplinary team that involves parents, guidance counselors, school psychologists, principals, and regular and specialized teachers. In cases where a child’s school refusal behavior is excessive in severity or frequency or in cases where extensive problems coexist with school refusal behavior, such as family dysfunction or depression, we recommend referral to a clinical psychologist who is familiar with the cognitive-behavioral treatment of this population. In our practice, consultations with school health professionals are common and often essential components of successful treatment, and we encourage such professionals to be active participants in addressing these youths.

References


