

**Letter to the Editor****School Refusal: Presentation and Management****Garima Srivastava, MA, Deepika Gupta, MA, Manju Mehta, PhD****Address for Correspondence:** Ms Deepika Gupta, PhD Scholar, Department of Psychiatry, All India Institute of Medical Sciences, New Delhi – 110029. Email: [deepika101@gmail.com](mailto:deepika101@gmail.com)

School refusal is defined by the following operational criteria: severe difficulty in attending school often resulting in prolonged absenteeism, severe emotional upset at the prospect of having to go to school, remaining at home with the knowledge of the parents during school hours, and absence of severe antisocial behaviour.<sup>1</sup> It is often associated with emotional distress (e.g. [separation anxiety](#), social [anxiety](#), depression); somatic complaints; learning disabilities; maladaptive coping skills; and family history of anxiety disorders and family stressors (e.g. parental divorce, prolonged illness, shifting residence).<sup>2</sup> School refusal affects approximately 1-2% of school children, and occurs in children of both genders aged 5-7 years and 11-14 years, owing perhaps to developmental vulnerabilities (e.g. starting school, transition to middle school).<sup>2</sup> Left untreated, school refusal can adversely affect the child's social, emotional and academic development, and adult health status.

**CASE REPORT**

Master R, an 11-year old student of class V, presented to the Child Guidance Clinic with refusal to go to school, decreased social interaction, and low self-esteem. The problems emerged over a 1-year period, following transfer from a Hindi-medium to an English-medium school. On detailed evaluation, he was also found to have somatoform, anxiety and behavioural (irritability and temper tantrums) symptoms. Temperamentally, he was sensitive to criticism and overly emotional. His developmental milestones and IQ scores were normal and he had no family history of mental illness. Draw-A-Person test indicated the presence of anxiety, feelings of inadequacy/insecurity, low self-esteem, and desire for environmental affection and contact. He rated his school related anxiety at 8/10.

The intervention followed a 3-phase schedule: psycho-education, anxiety management training, and social skills training. Twelve sessions were held over 8 weeks (first month: 8 sessions, second month: 4 sessions). The child and parents were cooperative, proactive and involved with the therapy sessions.

Post intervention assessment revealed significant improvement in terms of reduction in anxiety, resumption of regular schooling and enhancement of self-esteem and peer interaction. His scores on Strengths and Difficulties Questionnaire reduced from 17 to 13, and on the Childhood Behaviour Checklist from 45 to 30. Self-reported anxiety rating was 3/10.

**DISCUSSION**

In the psychoeducation phase, the child and the parent were helped to understand that the school refusal was due to interplay of factors: change of school and medium of instruction, temperamental vulnerability, perceived inability to cope with increased academic and social demands, and parent's inability to effectively adapt to the changed parental situation. To put things in perspective, the current problems were contrasted with successes in the previous school. Parents were taught principles of behaviour contracting (e.g. star charts)

to enhance consistent handling of the child, and they were encouraged and assisted in their efforts to ignore the child's somatoform complaints, undesirable demands and temper tantrums in accordance with stated guidelines.<sup>3,4</sup>

Anxiety management was initiated with systematic desensitization used in conjunction with brief relaxation training (active relaxation with guided imagery) and replacement of defeatist thoughts with adaptive coping self- statements. Researchers have demonstrated the efficacy of cognitive behaviour therapy in enhancing self-confidence and sense of control over situations and thus school going.<sup>4,5</sup> So, the child was trained to identify negative automatic thoughts, avoidance behaviour and the co-occurring somatic complaints. Behavioural experiments were designed with the mother's involvement to increase the child's confidence in dealing with anxiety evoking situations. Social skill training was imparted through role plays and behavioural experiments. The child was trained in communication skills, assertiveness and coping skills.

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