SCHOOL REFUSAL: CLINICAL FEATURES AND TREATMENT OUTCOME

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ABSTRACT

A retrospective study of 27 consecutive child-patients seen at the Child Psychiatric Clinic from 1976-81 for school refusal showed that there were more boys than girls with the condition. Students of all school grades were represented. The majority of them were of normal IQ. More of them complained of somatic symptoms than of psychological symptoms. 16 out of the 27 patients attended school successfully after treatment. Of the the 11 who failed to attend school, 9 were aged 10 and above and 3 of these 9 patients later exhibited psychotic symptoms. Of the 16 who returned to school, 8 of them did so within 8 weeks of treatment.

Keywords: Child psychiatry, school refusal, school phobia, clinical profile, outcome.

SING MED J. 1989; NO 30: 550-552

INTRODUCTION

Going to school is part of growing up in Singapore. It is a testing ground for the child as he or she takes his or her first step to independence. It indicates whether the child can cope on his or her own with the demands of the outside world. It is also a time for the parents to experience their first of several "letting go" of their child in the family life cycle.

To be fearful of attending school to the extent of non-attendance in a child is a great disappointment to parents and a surprise to some teachers.

Absence from school is a common problem encountered by teachers. A child may be kept away from school by parents on the pretext of illness, to keep a family or ill parent company or to do shopping or house chores.

School refusal is one of the causes of non-attendance at school. It is an emotional condition and is to be distinguished from truancy, one of the features of a conduct disorder. The term truancy applies to unjustifiable absence from school without the parents' knowledge or approval.

School refusal or school phobia refers to a syndrome the main features of which are:

1. Unwillingness to attend school because of fear.
2. Staying home when not at school.
3. Parents know about and disapprove of the child's absence.
4. Emotional upset at the prospect of having to attend school.

Fear may be based partly or fully on fear of separation from home or from the parent(s). It may be specific to the school environment and its related activities, in which case the term school phobia is more appropriate to use.

Generally, the problem may be formulated as resulting from an interaction of some disturbance of family relationship with a vulnerable temperament of the child and some school-related stresses.

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METHODS

This is a retrospective study of 27 consecutive child-patients seen for school refusal by the author in 1976-81 at the Child Psychiatric Clinic. The data were collected from the case sheet of each patient.

Some of the precipitating factors reported by the parents were as follows: attack of fever, 'flu, change of class, school or teacher, witnessing a funeral, bereavement and road traffic accident.

The somatic symptoms complained by the patients were as follows: aches and pains, headaches, tummyache, poor appetite, nausea, vomiting, chest discomfort, palpitation, giddiness, fainting and frequency of micturition. If the presentation involves a somatic complaint, any necessary investigations should be rapidly carried out to exclude the presence of a physical illness. School refusal has been called the "masquerade syndrome" by Waller and Eisenberg (1) because its presentation may mimic so many other medical conditions eg. viral infection, gastroenteritis, peptic ulcer, migraine and brain tumour.

The psychological symptoms consisted of complaints like: fearfulness, being clinging, self-absorbed, crying, screaming, scolding others, becoming angry at the mention of school, biting mother, throwing things, being violent, aggressive, temper tantrums, restlessness, insomnia and nightmares besides the refusal to go to school. Five of the patients refused to be separated from their parents at the clinic, 4 of whom were aged below 7 years and 1 was aged 10.

Some children had both somatic and psychological symptoms. A few also exhibited symptoms like hair pulling, poor concentration, breathing difficulty, losing interest in play, eating alone, suicide threats, hiding in the toilet and trance state.

Treatment at the Child Psychiatric Clinic consisted of a combination of the following methods: individual psychotherapy, behaviour modification, casework, school visits, medication and family therapy. Keeping the teachers informed of the treatment plan and dicussion with them played an important part in the management of the cases. About 60% of the patients successfully returned to school after treatment. In some cases, therapy involved not just helping the child-patient to return to school but also helping the parent(s) not to overprotect the child.

RESULTS

The clinical features of this group of patients are shown in Table I:

Table I

		No. of Patients
Sex		
Boys		17
Girls		10
Age		
6 – 12 years		14
13 – 17 years		13
Level of Education		
Primary 1 – 6		16
Secondary 1 – 4		11
IQ level		
> 109		1
90 – 109		15
70 – 89		5
< 70		2
Unknown		4
Temperament		
Shy, timid, sensitive, homely		15
Duration of Symptoms		
1 month or less		10
2 – 6 months		14
> 6 months		3
Presenting Symptoms		
Somatic symptoms		13
Psychological symptoms		8
Combines symptoms		6
No. of patients who reported precipitating factors		13
Birth Order	First Child	6
	Middle Child	12
	Youngest Child	9
Family Structure	Nuclear family	18
	Extended family	7
	Single parent	2
Ethnic Group	Chinese	20
	Malay	3
	Indian	3
	Eurasian	1
Sources of referral	Schools	15
	School Clinic	4
	General Hospitals	3
	General Practitioner	3
	Out-Patient Dispensary	1
	Lawyer	1
Time of Referral	1st half of the year	20
	2nd half of the year	7
Contact with other agencies before referral	Clinics/hospitals	16
	Spirit mediums	17

Of the 11 patients who failed to attend school inspite of treatment, 9 were more than 10 years old (including 3 who later exhibited psychotic symptoms). Of the 3 patients who showed psychotic symptoms, the change came 10 weeks, 4 months and 9 months after referral respectively. It appears that school refusal occurring in older children has a less favourable outcome. A proportion, about a third, was reported by Berg (2) to go on to have significant psychiatric disorder of the neurotic type in adulthood. Less frequently, school refusal develops into work refusal at school leaving age with features of an inadequate personality. The treatment outcome is shown in Table II.

Table II

Treatment Outcome	No. of patients
Attended school successfully	16
Attended school but later relapsed	3
Did not attend school at all	5
Manifested psychotic symptoms later on	3
Duration off school after referral in the 16 successful cases:	
< 2 mths	8
2-5 mths	5
6 mths-1 yr	3
Other treatment methods:	
Inpatient treatment	7
Medication	7

DISCUSSION

In 1932, Broadwin first described the condition of school refusal when he reported that there was a group of children whose "truant" behaviour concealed an underlying emotional condition which prevented them from going to school. Rutter and Hersov (3) quoted his description of the condition as follows:

"The child is absent from school for periods varying from several months to a year. The absence is consistent. At all times the parents know where the child is. It is with the mother or near the home. The reason for the truancy is incomprenhensible to the parents and the school. The child may say that it is afraid to go to school, afraid of the teacher, or say that it does not know why it will not go to school. When at home it is happy and apparently carefree. When dragged to school it is miserable, fearful and at the first opportunity runs home despite the certainty of corporal punishment. The onset is generally sudden. The previous school work and conduct had been fair."

Diagnosis of school refusal is clear - cut once the existence of such a condition is known to doctors and teachers. A characteristic feature is that the child is symptom-free when he or she is not asked to attend school. He or she is likely to feel well during weekends or holidays. In older children, there may be a past history of school adjustment problems eg. on starting kindergarten or Primary 1, the parents had to stay in school with them for a long period of time. Symptoms of school refusal may recur after a long holiday or after a few days off school for fevers or other childhood

infections. Some parents are themselves rather anxious and their children seem to catch that anxiety state from them.

Rutter (4) has worked out a scheme for the differential diagnosis of non-attendance at school.

In women, school phobia may emerge into agoraphobia or fear of leaving the house. A significant proportion of women with agoraphobia gave a history of school refusal in their childhood (5). Nevertheless, most children with school refusal grow up into healthy adults without major mental disorders.

REFERENCES

1. Waller D, Eisenberg L. School refusal in childhood – a psychiatric-paediatric perspective. In: Hersov L, Berg I. eds. Out of school. Chichester, John Wiley & Sons. 1980:209-29.
2. Berg I, Butler A, Hall G: the outcome of adolescent school phobia. Br J Psych 1976; 128:80-5.
3. Rutter M, Hersov L. Child and adolescent psychiatry. Oxford: Blackwell Scientific Publications. 1985:382.
4. Rutter M. Helping troubled children. Middlesex; Penguin Books. 1975:40-4.
5. Berg I, Marks I, Mcguire R, Lipsedge M: School phobia and agoraphobia. Psych Med 1974; 4:428-34.