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Children and Adolescents Presenting with School Refusal-A Clinical Study

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Summary :

Fifty-one consecutive children and adolescents who attended a child and adolescent psychiatric consultation center at Dhaka because of school refusal from January 1998 to December 2000 were included in this study to assess the pattern of presentation and underlying psychiatric conditions. For each case, thorough clinical assessment was undertaken using semistructured case assessment sheet. The cases were assigned ICD-10 clinical diagnoses of multiaxial classification of childhood and adolescent psychiatric disorder. Information was obtained at initial and subsequent contacts.

The cases of school refusal were 6% of the total cases of childhood and adolescence disorders. There was male predominance (male-female: 1.8:1, with mean age of 10.4 years (range 5 to 16 years) and majority of the cases belonged to middle economic status with urban background. The cases presented with anxiety, depression, and somatization symptoms. The commonest diagnoses in decreasing order were found to be separation anxiety disorder, specific phobia, depressive disorder, and somatoform disorder on Axis One. No diagnosis could be reached in 6 cases, although these children had considerable symptoms. Abnormal psychosocial situations were found to be associated with predisposition, onset, and course of the disorders in majority of the cases and most common was parental overprotection (61%). Overall, abnormal qualities of upbringing followed by acute life events were associated in most of the cases. Remarkable social impairments, particularly in the domains of academic and peer relationships were found among the cases.

The findings support the existing views of school refusal and suggest the need for detailed studies on nosology, description, trends, pathogenesis, management, and outcome of this problem in Bangladesh. It should be considered as a serious problem and timely intervention can improve the quality of life by preventing negative consequences.

Introduction :

A considerable number of children and adolescents referred for psychiatric consultation present with school refusal. School refusal is not a psychiatric disorder but presenting complaint that can reflect a variety of problems in the child, family, or school system as a whole. School refusal is salient because we live in a society that particularly values schooling. The term school refusal refers to an inability to attend school because of anxiety[1]. It is strictly not applicable in absence from school due to physical illness, withholding or truancy. In western countries, recent reviewers have concluded that school refusal occurs in approximately 5% of all school-age children[2]. It tends to be equally common in boys and girls[3,4]. For most cases, the socioeconomic status of the family is considerably mixed[5,6]. School refusal can occur throughout the entire range of school years but there are major peaks at certain ages and certain transition points in the child's life. It is more likely to occur between 5-6 years of age on starting school, 10-11 years of age with change of school and 14 years of age and older, and the commonest age of presentation is 11 years[5,7]. The school refusers present mainly with anxiety symptoms, somatization symptoms and/or depressive symptoms and can be a manifestation of a variety of underlying disorders[1,8].

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In Bangladesh, school refusal is gradually increasing and observed in child psychiatric consultation but any analysis on these disorders has yet not been reported. The present study has been carried out to assess the pattern of presentation of school refusal and its impact in the form of psychosocial disabilities, and to delineate the underlying psychiatric disorders.

Materials and methods :

The study was carried out in a private Child and Adolescent Consultation Center run by the author (a child and adolescent psychiatrist) in Dhaka during the period from January, 1998 to December, 2000. All the consecutive new cases of school refusal referred to the center within 16 years of age were included in the study after taking informed consent from the patients and their families. The operational definition of school refusal was 'refusal to go or stay in school, even under pressure, on account of anxiety or misery'. In each case, thorough clinical assessment was undertaken at the time of first assessment or subsequent series of assessments whenever required using semistructured case assessment sheet consisting of sociodemographic parameter, information on school refusal, history and clinical findings. Where necessary, relevant clinical examinations and laboratory investigations had been performed to rule out any possibilities of having organic causes to explain the presenting symptoms. The cases were diagnosed by the author on the basis of ICD-10 clinical diagnoses of multiaxial classification of childhood and adolescent psychiatric disorder[9] and were recorded according to Axis One of this classification, which comprises clinical psychiatric syndromes. These clinical diagnoses were phenomenologically based following diagnostic guidelines of somatoform disorders. Associated abnormal psychosocial situations of the patients during the period of assessment were recorded according to Axis five of this classification. This axis provides a means of categorizing those aspects of the child's psychosocial situation that are significantly abnormal in the context of the child's level of development, past experiences and prevailing sociocultural circumstances. The assessment was carried out on the basis of the guidelines for the categories. Global assessments of the patients' psychosocial disabilities at the time of clinical evaluation were recorded according to Axis Six of the classification. This axis concerns disabilities in functioning that have arisen as a consequence of psychiatric disorder. Disabilities were rated on the basis of the patients' lowest level of functioning in psychological, social and educational domains during the last 3 months. The diagnoses were based on extensive information on symptoms, associated abnormal psychosocial situations and resultant psychosocial disability from parents and other accompanying reliable informants. The data was processed and analyzed.

Results :

Out of total 850 children and adolescents attending the center during the study period, 51 cases had school refusal comprising 6% of the clinic population.

Among the cases, 33 were boys and 18 were girls. The boy and girl ratio was 1.8:1. Their age ranged between 5 and 16 years with a mean of 10.41(SD=3.53) years. The largest number of cases were in the age group of 5-7 years and 14-16 years with 15 cases for each. Urban and rural distribution of the cases were 36 and 15 respectively. Thirty-one cases were predominantly of middle-income group and the rest 20 cases belonged to higher class. Regarding educational status, 9 were preprimary, 22 were primary, and 20 were of secondary level.

The source of referral of the cases revealed that paediatricians referred 22(43.14%) cases, which formed the largest group followed by 11(21.57%) cases who were brought directly by their parents. Internists referred 6(11.77%) cases, neurologists referred 5(9.80%) cases, and 3(5.88%)cases were referred from specialists of other disciplines. General practitioners referred only 4(7.84%) cases.

Regarding the type of onset of school refusal, acute and gradual onset was found in 30(58.82%) and 21(41.18%) cases respectively. Duration of the absence from school ranged from 2 weeks to 12 months with the mean of 3.8(SD=1.87) months.

Analysis of the presenting symptoms revealed that overall, the cases predominantly presented with multiple somatic symptoms, anxiety, and/or depressive symptoms. Table-I shows the underlying psychiatric diagnoses. It revealed that separation anxiety disorder and specific phobia were the two most prevalent psychiatric disorders with 10 (19.61%) and 9(17.65%) cases respectively followed by 8(15.69%)cases of depressive disorder and 6(11.76%) cases of somatoform disorder. Schizophrenia was found in 2 cases and 1 case was of post-traumatic stress disorder. In 6 cases, no diagnosis could be reached though these children had remarkable symptoms.

Table-I

Cases by Underlying Diagnoses of Clinical Psychiatric Syndromes (n = 51)

Psychiatric Syndrome	No	Percent
Separation anxiety disorder	10	19.61
Specific phobia	9	17.65
Depressive episode	8	15.69
Somatoform disorder	6	11.76
Social phobia	3	5.88
Adjustment disorder	2	3.92
Post-traumatic stress disorder	1	1.96
Hyperkinetic disorder	2	3.92
Stuttering	1	1.96
Mixed anxiety and depressive disorder	1	1.96
Schizophrenia	2	3.92
No diagnosis	6	11.76

Table-II shows the associated abnormal psychosocial situations of the cases. More than one situation were recorded. It indicated that parental overprotection was the most common abnormal psychosocial situation (60.78%). Inappropriate academic pressure and inappropriate parental pressure were found in 15.69% and 11.76% respectively. Relocation and/or change of school was found in 11.76% cases. Parental mental disorder was recorded in 5(9.80%) cases (depressive disorder and panic disorder were of 2 cases for each and 1 case was of phobic anxiety disorder). Some other life events were also recorded in 10 cases and no associated abnormal psychosocial situations were found in another 10 cases.

Table-II

Distribution of Cases by Associated Abnormal Psychosocial Situation (n = 51)

Situation	No	Percent
Parental overprotection	31	60.78
Inappropriate parental pressure	6	11.76
Inappropriate academic pressure	8	15.69
Changes in school or relocation	6	11.76
Parental mental disorder	5	9.80
Intrafamilial discord among adults	3	5.88
Personal frightening experience	1	1.96
Loss of love relationship	2	3.92
Sexual abuse	2	3.92
Discordant relationship with peers	2	3.92
No abnormal situation identified	10	19.61

* more than one situation were recorded

Global assessment of the patients' psychosocial disability at the time of clinical evaluation was recorded which is shown in Table-III. Some form of disability was found in all cases. Slight social disability was the largest category found in 23 cases followed by moderate social functioning in 15 cases. Serious social disability was found in 2 cases. Among the domains, major areas of impairment or difficulties were of academic and peer relationships.

Table –III

Distribution of Cases by Global Assessment of Psychosocial Disability (n = 51)

Degree of Disability	No	Percent
Moderate social functioning	15	29.41
Slight social disability	23	45.10
Moderate social disability	11	21.57
Severe social disability	2	3.92

Discussion :

The widely acceptable definition of school refusal is difficulty in attending school associated with emotional distress, which has been applied in the present study. However, debates continue in the literature as to whether or not the construct of school refusal should also include truancy, school attendance problems associated with antisocial behaviour and conduct problems[2]. Clearly, interpretation of studies' on school refusal must take into account these definitional issues.

From this study, the cases of school refusal were found to be 6% of the child psychiatric referral. It is assumed that the referral of the cases of school refusal could be more. The presenting symptoms were mainly somatic without overtly expressed emotional problems and these symptoms were the main reason for consultation rather school refusal itself. However, 22% cases were directly brought by their parents for psychiatric consultation which reflects the increased awareness among the parents about school refusal and possibilities of having psychiatric problems among such cases.

It has been observed from sociodemographic characteristics that school refusal was found more among the age group of 5 - 7 years and 14-16 years that are more or less consistent with the findings of other studies[5-7]. However, boys outnumbered girls and

excess of urban cases with higher or middle economic background in this study do not simulate the findings of Western studies and at least in part, can be explained as sample biases.

In the present study, school refusal was associated mainly with somatoform, anxiety, and depressive symptoms. Somatic symptoms without identified pathology were predominant. These findings are similar with the reports of other studies[10-14]. In an investigation of anxious/depressed adolescent school refusal, it has been reported that these teenagers frequently report moderate or severe somatic complaints. The most common somatic complaints were of the autonomic and gastrointestinal type[14]. Therefore, it can be said that tendency of somatization is common in school refusers. In the majority of the cases (88%) there were underlying psychiatric diagnoses in this study. The results are roughly consistent with the findings of several representative studies[14-16]. Berny et al[15] found that separation anxiety was moderate or marked in 87% of 51 children aged 9 to 15 with school refusal. Bernstein & Garfinkel[16] reported that 69% of 26 early adolescents, chronic school refusers met DSM-III criteria for either major depression or adjustment disorder with depression. Last and Strauss[6] conducted a major investigation of anxiety-based school refusal. The authors examined 63 school-refusing children and adolescents (aged 7-17 years) referred to an outpatient anxiety disorders clinic. According to DSM-III-R criteria, the most common primary diagnoses included separation anxiety disorder (38%), social phobia (30%) and simple phobia (22%). Less frequent diagnoses included panic disorder and post-traumatic stress disorder.

In the present study, 90% cases had had some sort of associated abnormal psychosocial situation with the predisposition, onset, and course of the disorders. Parental overprotection was found to be the single largest factor of the abnormal qualities of upbringing to contribute to school refusal possibly expressed mainly in the form of maladaptive coping behaviour. Furthermore, school refusal usually results from a combination of the child's unwillingness to attend and parental inability or unwillingness to make them go[8]. Inappropriate academic pressure was found to be the second most frequent situation that might be considered as an increasing cause of school refusal as well as for other disorders in childhood and adolescence. Other abnormal psychosocial situations found in this study were also important as causal influences. Particularly, parental mental disorder was found in 10% of cases in the form of depressive disorder, panic disorder, and phobic anxiety disorder. A study among the parents of anxious school refusing children revealed that increased prevalence of simple phobia and simple and/or social phobia among the fathers and mothers of phobic disorder and panic disorder and/or agoraphobia among the fathers and mothers of school refusers with separation anxiety disorder[17].

Psychosocial disabilities in functioning that have arisen as a consequence of psychiatric disorder are considered as impact of the disorder in patient's life. In this study, some degree of social disability was found in all cases particularly in the domains of academic and peer relationships. School refusal was found to be associated with sequelae including poor academic performance, family difficulties and peer relationship problems and social difficulties reported in the longitudinal studies [6,18,19]. Clearly, school refusal interferes with the child's social and educational development and other adverse consequences and therefore, should be regarded as a serious problem.

Conclusion :

To researcher's knowledge, the present study is the first to explore the clinical pattern of school refusal in children and adolescents in Bangladesh. Findings suggest that school refusers are recognizable in clinical practice and support the existing views of school refusal, reflected in the findings of several studies: Considering its serious consequences, school refusal needs rapid management and return to school.

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