SCHOOL REFUSAL : CLINICAL CHARACTERISTICS, TREATMENT AND OUTCOME

This dissertation is presented in partial fulfillment for the degree of Master of Philosophy in the Faculty of Medicine, University of Cape Town.

by

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"I, Leon Anton Engelbrecht, declare that this dissertation embodies only my original work except where acknowledgement indicates otherwise and that no part of it has been, or is being submitted for a degree at this or any other university."

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SCHOOL REFUSAL : CLINICAL CHARACTERISTICS, TREATMENT AND OUTCOME

PART I - INTRODUCTION AND REVIEW OF THE LITERATURE.

Chapter 1: Introduction - general aims of the study.

Chapter 2: Review of the literature - historical perspectives, clinical characteristics, aetiology, treatment and outcome.

PART II - THE RESEARCH STUDY

Chapter 3: Research Design

Chapter 4: Report of the Results

Chapter 5: Discussion of the Results

Chapter 6: Conclusion and recommendations.

ACKNOWLEDGEMENTS

REFERENCES

APPENDIX

CONTENTS

ABSTRACT iv

PART I - INTRODUCTION AND REVIEW OF THE LITERATURE 1

CHAPTER 1 - INTRODUCTION - GENERAL AIMS OF THE STUDY 1

1.1 INTRODUCTION 1

1.2 GENERAL AIMS OF THE STUDY 2

1.3 THE FORMULATION OF HYPOTHESES 3

1.4 SUMMARY 3

CHAPTER 2 4

REVIEW OF THE LITERATURE - HISTORICAL PERSPECTIVES, CLINICAL CHARACTERISTICS, AETIOLOGY, TREATMENT AND OUTCOME 4

2.1 HISTORICAL PERSPECTIVES 4

2.2 ORIGIN OF THE CONCEPT OF SCHOOL REFUSAL 6

2.3 INTRODUCTION 8

2.4 DEFINITION OF SCHOOL REFUSAL AND TRUANCY 8

2.4.1 School refusal 8
2.4.2 Truancy 9

2.5 DISTINCTION BETWEEN SCHOOL REFUSAL AND TRUANCY 9

2.6 PREVALENCE 11

2.7 GENERAL DESCRIPTION 12

2.8 SUB-CLASSIFICATION 14

2.8.1 Extensiveness of disturbance 14
2.8.2 Summary 17
2.8.3 Source of fear 17

2.9 GENDER 19

2.9.1 Summary 19

2.10 SOCIOECONOMIC STATUS 20

2.11 ORDINAL POSITION 20

2.12 FAMILY INTERACTION IN SCHOOL REFUSAL 20

2.13 "MASQUERADE SYNDROME" 23

2.14 DEPRESSION AND ANXIETY IN SCHOOL REFUSAL 25

2.15 SUMMARY 27

2.16 AN ASSESSMENT AND TREATMENT PLAN IN SCHOOL REFUSAL 27

2.16.1 Introduction 27
2.16.2 Assessment 28
2.16.3 Treatment 31

2.17 OUTCOME 37

2.18 CONCLUSION 38

PART II - THE RESEARCH STUDY 40

CHAPTER 3 RESEARCH DESIGN 40

3.1 INTRODUCTION 40

3.2 RESEARCH DESIGN 40

CHAPTER 4 43

RESULTS 43

CHAPTER 5 62

5. DISCUSSION OF RESULTS 62

5.1 INTRODUCTION 62

5.2 DISCUSSION OF RESULTS 62

5.2.1 Identifying data 62

5.3 SOCIO-ECONOMIC FACTORS 63

5.4 FAMILY FACTORS 64

5.5 SOURCES OF REFERRAL 65

5.6 CLINICAL CHARACTERISTICS 65

5.7 TREATMENT 66

5.8 OUTCOME 67

CHAPTER 6 69

6. CONCLUSION AND RECOMMENDATIONS 69

6.1 CONCLUSION 69

6.2 RECOMMENDATIONS 70

6.3 FUTURE RESEARCH 71

REFERENCES 73

APPENDIX 1

APPENDIX 2

APPENDIX 3

APPENDIX 4

APPENDIX 5

APPENDIX 6

ABSTRACT

Clinical characteristics, methods of treatment and outcome in School Refusal have been investigated.

School refusal/phobia has been reported in the literature not to be a true clinical entity with a uniform aetiology, psychopathology, course, prognosis and treatment, but rather a collection of symptoms or a syndrome occurring against the background of a variety of psychiatric disorders. Aetiological and precipitating factors also vary with age, psychosocial level of development and personality factors in the individual child, family structure and function, and the school setting.

Data were collected retrospectively from 20 cases treated at the Child and Family Unit, Red Cross War Memorial Children's Hospital, Cape Town during a specific time period.

Analysis of the data revealed a gender distribution of 11 boys and 9 girls; 1 girl, 5 - 8 years old and 11 boys and 8 girls 9 - 13 years old. One Asian, no Black, 13 Coloured and 6 White children were represented.

A large section of the sample population represented the lower socio-economic group as determined by parental qualification and occupation. Most of the families tended to consist of more than 2 children (5 member families). Family dysfunction was recorded in all but one case, with evidence of a recognizable psychiatric disorder also recorded quite frequently in the nuclear family members.

Educational difficulties were recorded in a third of the sample together with below average total IQ scores in virtually all the subjects evaluated.

The bulk of referrals were from medical practitioners and relatively few from schools.

Refusal to attend school was of relatively short duration in three-quarters of the sample. Most of the cases were first time school refusers.

Accompanying symptoms or problems were mainly anxiety or depression - related whereas significant associated events were mainly family - oriented.

Psychiatric disorders diagnosed most often were anxiety and affective disorders with overlap of the 2 conditions recorded in half the sample.

Response to treatment was positive in two thirds of the sample and a combination of treatment methods proved to be the most successful treatment plan.

School refusal as investigated in this study, was well represented in a population of children treated at a Child Psychiatric Out-Patient Unit. A high rate of resemblance on various aspects of school refusal was recorded between the study sample and reports in the literature reviewed.

PART 1 - INTRODUCTION AND REVIEW OF THE LITERATURE

CHAPTER 1 - INTRODUCTION: GENERAL AIMS OF THE STUDY

1.1 INTRODUCTION

Absence from school is a common problem encountered by teachers and others who work in the field of education, by general practitioners and other workers in the primary health care field, paediatricians or psychiatrists treating children and their families, by social workers who deal with young people and their families in a variety of circumstances, and by psychologists who study and treat children (Hersov & Berg 1980).

School non-attendance does not refer to a single diagnostic entity, it rather encompasses the broad categories of truancy and school refusal/school phobia. Factors such as age, sex, and social background are important factors in determining the prevalence of unjustifiable absence from school. The term truancy refers to unjustifiable absence from school without the parents knowledge or approval. Truancy is also seen as one of several kinds of antisocial behaviour such as stealing, lying, destructiveness, and excessive fighting. Associated educational difficulties are often present and children from poor homes are predominantly affected

On the other hand school refusal/school phobia refers to a syndrome the main features of which are unwillingness to attend school, staying home when not at school, parents who know about and disapprove of the child's absence, severe emotional upset at the prospect of having to attend, and the absence of antisocial behaviour such as stealing, lying, destructiveness and excessive fighting.

School refusal is also found in relation to different types of parental care. When parental guidance is inadequate, separation anxiety is often of central importance. In other instances it is often found that parents are unable to provide firm support which would help a neurotic child to overcome his aversion to school.

The increased recognition of the important role school factors play in some cases of school refusal led to the inclusion of these factors when trying to understand the psychological mechanisms underlying each child's behaviour and also in planning treatment to re-establish regular attendance.

Various associated psychiatric disturbances are commonly found in children presenting with school refusal. The two disorders most commonly encountered are anxiety and affective disorders. Separation anxiety disorder occurs more frequently in the younger age group whereas depressive disorder is diagnosed more frequently in the older child and adolescent.

Treatment strategies with the purpose of returning the child to school as soon as possible and of alleviating any associated psychiatric disorder include the full range of available facilities. The outcome, irrespective of the method(s) used is usually good.

School refusal can be followed by various problems in adult life, such as occupational dysfunction or anxiety disorder with agoraphobic symptoms.

1.2 GENERAL AIMS OF THE STUDY

The aim of this study is to describe, retrospectively, the clinical characteristics, treatment and outcome of 20 children treated for school refusal at the Child and Family Unit, Red Cross War Memorial Children's Hospital, Cape Town. The required data will be extracted from the corresponding clinical files.

Why school refusal?

School refusal continues to be an interesting clinical entity to investigate, mainly because of the complexity of presentation and psychopathology. It also serves as an example of neurotic disorders in children, for it illustrates with special clarity the relation between symptoms in the child, the psychological structure of the family and intrinsic school factors. The management of these cases not only highlights general considerations in the psychotherapy of emotional disorders in children, it also calls for a concerted effort to coordinate the therapeutic efforts of the physician, school authorities and participating school agency if the rehabilitation of the family unit is to be successful.

These factors also served as the main reason for choosing this particular topic.

1.3 THE FORMULATION OF HYPOTHESES

A hypothesis can be described as a logical supposition, a reasonable guess or an educated conjecture (Leedy 1989). Hypotheses can also be viewed as small versions of theories, a small body of propositions in contrast to the large body of interconnected propositions of theory (Kidder 1981). Hypotheses can be used differently in various research designs; as descriptive or explanatory and as hypothesis testing (deductive research) or hypothesis generating (inductive research) (Kidder 1981; Forcese & Richer 1973). After the hypotheses, come facts. The facts subsequently either support or fail to support the hypotheses.

The type of hypothesis put forward for this study is a descriptive hypothesis, postulating that school refusal/phobia is a universal phenomenon and that the clinical characteristics, methods of treatment and outcome as ascertained from the cases treated for school refusal at the Child and Family Unit, Red Cross War Memorial Children's Hospital, will therefore not differ substantially from studies reported in the literature.

Inference will also be drawn from this study on

(a) the most significant clinical characteristics of the cases of school refusal seen at the Child and Family Unit; and

(b) methods of treatment most likely to be effective.

1.4 SUMMARY

Being a descriptive study, it will not be possible to determine causes of any of the aspects to be described. The study, being a clinical study, will not be representative of all cases presenting with school refusal. The reason for this is that a number of cases presenting with school refusal are managed successfully by other professionals who deal with children and their families. They are therefore never referred to a child psychiatric clinic. A study such as this can also be useful to the workers at the Unit, especially if findings from the study can assist them in managing similar cases more effectively.

CHAPTER 2

REVIEW OF THE LITERATURE - HISTORICAL PERSPECTIVES, CLINICAL CHARACTERISTICS, AETIOLOGY, TREATMENT AND OUTCOME

2.1 HISTORICAL PERSPECTIVES

Going to school is part of growing up in a Westernized society. The path leading from the relatively dependent protected state of childhood to the state of responsible independence that characterizes the adult is a path that leads through the scholastic system. Acquiring a formal education is crucial if a child is to be able eventually to provide for himself or herself, but formal education per se is only part of what school attendance provides along the route from dependence to independence. Of equal importance is a gradual extension of relationships from within the family to relationships within the community, (Kahn & Nursten 1962) as the primary attachments to parents and home are gradually attenuated by separation and supplemented by increasingly important ties to others (Waller & Eisenberg 1980).

In the Western world, the school aged child is expected to tread this path five or six days a week - indeed laws often require it, making school attendance one of the few aspects of human development legally enforceable. Similar guidelines are laid down for the South African situation in the White Paper on the Provision of Education in the Republic of South Africa (1983). The only exception, for whom school absence is sanctioned is the child who is ill, as long as the child is deemed too sick to attend. It is assumed that an ill child is in need of a temporary return to the extra care and protection of home in order to gather once again the necessary resources to continue along the path toward school and maturity (Waller & Eisenberg 1980).

It is also clear that going to school makes many demands upon a child which alter with age and school progress. Klein (1945) described school as the first testing ground in society that lies outside the more protecting atmosphere of home. Going to school involves the first of many continuing separations from home and submission to outside rules and standards in a situation from which there is no escape and over which little control can be exerted. Parents are unable to intervene to save the child as they may have done up till

now. Anxiety about separation from mother and home can become overwhelming and alter attendance.

Going to school means a new and exacting situation imposing many pressures. New skills are learned but there is also the chance of relative failure instead of recognition and demands have to be faced often without preparation, in competition with peers and under the eye of a mainly impersonal adult authority. A child is judged at school by performance, rather than by reputation and intention, and by qualities for which he is not responsible such as intellectual endowment, or social class. He is exposed to competitive physical activity and rougher children. It can also be very stressful for a pre-pubertal or late-maturing child to be in a class with mature early adolescents who are more worldly and have very different interests and aspirations (Hersov 1985).

Reluctance to go to school is certainly not a new phenomena for Shakespeare had already immortalized it in his Seven Ages of Man in "as you like it" (II VII 139).

> *"And then,*
> *The whining schoolboy with his satchel,*
> *and shining morning face,*
> *creeping like a snail,*
> *Unwillingly to school!"*

Schooling in Europe started off being voluntary and fee paying, almost entirely for the children of the wealthier educated classes. Western societies now take it for granted that all children should have appropriate free education and in law it is the parents' responsibility to ensure they receive it, most often by regular attendance at school (Hersov 1987).

School non-attendance only became an educational problem since the introduction of compulsory education. The laws making education compulsory were introduced in Europe and the United States during the 19th century.

Compulsory education, in the South African context, has been introduced at different stages for the different population groups as each group has its own Department of Education. Education for blacks differs from education for the other population groups as it is not yet compulsory.

At first the parents in working class families could see little or no benefit in compulsory education that they had not experienced themselves. These families also reacted with anger and opposition to these measures as their children were often a source of income and support. In rural areas, children were and still are kept at home to help with the harvest (Hersov 1987).

At first all non-attenders were called "truants" derived from an Old French and Middle English word meaning "an assemblage of beggars". The usage of the word truancy changed from an initial association between truancy, idleness and vagabondage to describe a lazy idle person especially a boy who absents himself from school attendance without leave (Hersov 1987). Truancy was considered to be a precursor of delinquency and school boards appointed men to ensure regular attendance.

2.2 ORIGIN OF THE CONCEPT OF SCHOOL REFUSAL

Early studies into school non-attendance highlighted differences in the family backgrounds and the general behaviour patterns of school non attenders. Truancy was linked with adverse social and economic conditions, marital breakdown, physical punishment at home, and poor progress at school (Farrington 1980). Today truancy still occurs most often against a similar background of adversity and is usually regarded as a manifestation of a Conduct Disorder (DSM-III-R 1987) along with other anti-social behaviour. It carries with it a high risk of delinquency and later of lower status jobs, unstable work history, a higher level of more serious antisocial behaviour and a likelihood of conviction. However not all truants become delinquents (Farrington 1980).

Another group of children presenting with persistent non-attendance came from more stable home backgrounds, were not anti-social and did not become delinquent. They did not wander about the streets alone or in the company of other truants, but remained at home in close proximity to one or both parents, usually the mother.

In 1932 Broadwin described a type of school non-attendance which he maintained differed from the usual pattern of truancy as follows:

> "I wish to describe a form of truancy which may have received little attention. It occurs in a child who is suffering from a deep seated neurosis of the obsessional type or displays a neurotic character of the obsessional type. The truancy is part of

the general symptomatology and part of a multiplicity of personality difficulties which have received little corrective attention.

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 incomprehensible to the parents and the school. The child may say that it is afraid to go to school, afraid of the teacher, or say it does not know why it will not go to school. When at home it is apparently care-free. 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 conducts had been fair." (Broadwin 1932).

This description remains a classic for clarity and vividness.

This clear description of a variant of common truancy was the forerunner of what would later be called "School phobia" and "School Refusal".

It is also an interesting early example of the continuing effort in child psychiatry to delineate clinical syndromes according to rational principles, with an aetiology, phenomenology, psychopathology, prognosis and treatment (Hersov 1987).

In 1941, Johnson and her colleagues coined the term "School Phobia" to describe a particular form of non-attendance as follows:

"The syndrome, often referred to as "school phobia", is recognizable by the intense terror associated with being at school. The child may be absent for periods of weeks or months or years, unless treatment is instituted. The children, on fleeing from school, usually go straight home to join the mother. Eventually they refuse to leave the house. When the child is superficially questioned, he cannot verbalize what the fears are and the whole matter appears incomprehensible to parents and teachers" (Johnson 1941).

The description also favoured the explanatory mechanism of phobic projection on to school or teacher.

School refusal however is considered a more appropriate description of the child's behaviour than school phobia by many clinicians and family therapists because it does not

imply a commitment to a particular theory of psychopathology such as the origin of phobias, nor does it assume that we are dealing with a unitary homogeneous disorder.

The terms school refusal and school phobia are however used interchangeable by some clinicians while others (Last et al 1987) tend to differentiate between school phobia and separation anxiety.

2.3 INTRODUCTION

School refusal/phobia is not a true clinical entity with a uniform aetiology, psychopathology, course, prognosis and treatment, but rather a collection of symptoms or a syndrome occurring against the background of a variety of psychiatric disorders (Hersov 1960a; Hersov 1960b; Davidson 1960; Millar 1961; Kahn & Nursten 1962 and Shapiro & Jegede 1973). The precipitating and aetiological factors vary with age, school setting, family structure and function, psychosocial level of development and personality factors in the individual child (Hersov 1985).

The problem starts with vague complaints of school or reluctance to attend, progressing to total refusal to go to school or to remain in school in the face of persuasion, entreaty, recrimination, and punishment by parents and pressure from teachers, family doctors and welfare officers. The behaviour may be accompanied by overt signs of anxiety or even panic when the time comes to go to school, and most children cannot even leave home to set out for school. Many who do, return home half-way there, and some children once at school rush home in a state of anxiety. Many children insist that they want to go to school and prepare to do so but cannot manage it when the time comes. Characteristically, they remain at home with their parents knowledge when they should be at school (Hersov 1985).

2.4 DEFINITION OF SCHOOL REFUSAL AND TRUANCY

2.4.1 School refusal

Failure to attend school, despite the physical capacity to do so, takes many forms. Berg (1980) offered an operational definition which consisted of 4 criteria:

(1) Severe difficulty in attending school usually amounting to prolonged absence.

(2) Severe emotional upset when faced with the prospect of going to school, including excessive fearfulness, undue tempers, misery, and complaints of feeling ill without an organic cause being found.

(3) Staying at home with the knowledge of their parents when they should be at school.

(4) Absence of significant anti-social disorders, such as stealing, lying, wandering, and destructiveness.

The latter two criteria distinguish the school refuser from the truant. Several authors have mentioned a third distinguishing characteristic: The absence of the truant tends to be sporadic and for short intervals whereas the school refuser is absent for several consecutive days, weeks or even months (Atkinson et al 1985).

2.4.2 Truancy

The term truancy, when narrowly defined, applies to unjustifiable absence from school without the parent's knowledge or approval. It is in fact sometimes used more loosely to refer to absence from school without an acceptable reason, whether or not the parents know and approve.

The clinical view of truancy is that staying off school is one of several kinds of anti-social behaviour such as stealing, lying destructiveness and excessive fighting. Associated educational difficulties, often present as well, make the tendency to stay away from school comprehensible. The fact of the parents not being aware of their child's absence, focuses the problem squarely on the child's deviant conduct (Hersov & Berg 1980).

2.5 DISTINCTION BETWEEN SCHOOL REFUSAL AND TRUANCY

Broadwin in his original observations (Broadwin 1932) described a group of persistent non-attenders as a variant of common truancy. The psychoneurotic elements found in this group constituted the differentiation from truancy.

Johnson et al (1941) also referred to the deep seated psychoneurotic disorder in the group of school non-attenders that differentiated them from the delinquent variety of school truancy.

In a study Hersov (1985) systematically comparing equal numbers of truants, school refusers and control cases found that children referred for school refusal came from families with a higher incidence of neurosis, had less experience of maternal absence in infancy and childhood, were more often passive, dependent and overprotected, but generally showed a high standard of work and behaviour at school. Their school refusal was most often one manifestation of a neurotic disorder in which anxiety and depressive affect were prominent. On the other hand children referred for truancy came from larger families where home discipline was inconsistent and had more often experienced paternal absence in infancy and in later childhood. They had changed school frequently and their standard of work was poor. Their truancy was an indication of a conduct disorder that often involved other anti-social or delinquent behaviour.

Other investigators found that children with school refusal differed from truants in that the former came from smaller families of a higher socio-economic level where home discipline was overanxious in quality whereas the truants came from families lacking in concern about school attendance, which was reflected in the children by carelessness and defiance of school authority. Certain features said to be characteristic of school refusal also occurred among truants on remand. These were, a marked anxiety about going to school, returning home when truanting from school rather than roaming alone or in company, anxiety about events at home when at school, and psychiatric symptoms of an effective type. This suggests the coexistence of neurotic and conduct disorders in boys on remand for school non-attendance.

Hersov (1985) proposed that school non-attenders seen at psychiatric clinics may differ from those in remand homes. This was supported by his earlier findings (Hersov 1960a; b) that the majority of truants referred to a psychiatric clinic had appeared in a juvenile court for reasons other than non-attendance compared with only one case of school refusal. School refusers seen in a clinical setting were found to be less likely to lie and steal. Whereas conduct disorder was more commonly diagnosed than emotional disorder when truants presented with psychiatric symptoms or signs. A small number will also show anxiety symptoms and social isolation of the same order as those non-attenders diagnosed as school refusal. School refusers on the other hand are highly unlikely to display anti-social behaviour and the great majority show clear evidence of emotional disorder. Their

pattern of non-attendance has a distinctive form and quality different from that of truants. The family structure and pattern of relationships and parental management of the children is also very different in the two forms of non-attendance.

2.6 PREVALENCE

The prevalence of school refusal has proved difficult to establish as most of the earlier estimates were based on clinical populations covering a wide range of children who had been referred to child psychiatric or child guidance clinics. However, Smith (1970) reports that 3,8% of children with neurotic disorders seen at the Maudsley clinic, presented with school refusal, and Chazan (1960) and Kahn and Nursten (1962) report school phobias as ranging from 1 to 8 % of their clinic cases seen in a ten year period.

However a prevalence of less than 3% was found of all children with psychiatric disorders, in a total population of 10 and 11 year old children on the Isle of Wight (Rutter et al 1970). Various investigators (Adams et al 1966 and Rabiner & Klein 1969, Hersov 1985 and Heath 1983) have noted the low prevalence of black children with school phobia attending clinics in the USA and in South London. Rutter et al (1974) found a surprisingly low figure for non-attendance at school generally among 10-year old West Indian children in an inner London borough.

Family doctors are also very likely to deal effectively with early or incipient cases of school refusal which never reach a psychiatric or child guidance clinic. Shepherd et al (1966) found in a study that four-fifths of a sample of general practitioners indicated that they would themselves manage a straight forward case of persistent school non-attendance while one-fifth would refer such children to a clinic. Rutter et al (1976) in a study of 14-year old Isle of Wight children, found a higher incidence of school refusal either in association with an affective disorder or with other psychiatric symptoms as compared to the negligible prevalence at age 10 and 11 years. A reasonable estimate overall of clinical incidence would be about 5% of all children referred for psychiatric disorder with a higher rate in early adolescence and in secondary schools than in infant or primary schools (Hersov 1985).

The various studies show a pattern of prevalence that appears highest at three periods of school-going age. At entry and soon after between the ages of 5 and 7 years (probably associated with separation anxiety), at 11 years associated with change of school and a variety of neurotic disorders, and again at 14 years and older. The latter group may be a

substantially different group regarding the type, and severity of psychiatric disorder, frequency of depressive states, and in the outcome of treatment and prognosis (Hersov 1985). It was also found to affect boys and girls equally without any definite social class bias (Berg 1980).

2.7 GENERAL DESCRIPTION

Boys and girls presenting with school refusal are equally affected, are from homes of varied economic levels and of low average to extremely superior intelligence. Educational attainment also varies from poor to beyond expectation (Hersov 1960a and Berg et al 1975).

Precipitating factors were frequently found at all ages. These factors included an organic disease or operation, leaving home for a school holiday or camp, a move to a new house, a change of class or school, the departure or loss of a school friend, the death or illness of a relative to whom the child was closely attached. All these events appear to represent a threat to the individual child, arousing anxiety that he cannot control (Hersov 1985 and Johnson et al 1941). Other precipitating factors include an increase of anxiety in the mother due to some simultaneously operating threat to her satisfactions, such as sudden economic deprivation, marital unhappiness, illness etc. A strikingly poorly resolved early dependency relationship of these children to their mothers, always seems to be present (Johnson et al 1941). Morbid dread of some aspect of the school situation can also cause a strong reluctance to go to school. The specific fear may be of a teacher, another child, or almost any aspect of the school. As the time for departure from home to school approaches, anxiety rapidly rises to massive proportions and is invariably accompanied by somatic symptoms, usually nausea, and vomiting, less seldom headaches, elevated temperature, sore throat or leg pains. If there is parental insistence that the child proceed to school, the boy or girl becomes desperate and panicky and may physically resist attempts to propel him/her to the bus or car. When such attempts are abandoned and the child is allowed to remain at home, the anxiety rapidly abates, the somatic symptoms melt away, and the child returns to a seemingly contented and cheerful state (Coolidge 1979).

The onset of the syndrome of school refusal (Millar 1961) can be such that the child does not directly refuse to attend school. More frequently somatic complaints such as abdominal pain or nausea, headaches or dizzy spells raise a question in the parents' minds about the advisability of sending the child to school. These physical complaints tend to recede quickly if the child is permitted to remain home but they are frequently aggravated if the

child is taken to school. Millar argues that these symptoms are sometimes vegetative concomitants of anxiety feelings, but is however doubtful if they should be accorded the dynamic status of conversion reaction.

If the parent attempts to force the child to attend school, the refusal aspect of the non-attendance becomes more evident. The child will often become anxious, make protestations of pain and fear. Frequently a particular child is unable to specify what he fears. At times if pressed, he may offer a rationalization of his behaviour in terms of a strict teacher or principal, unfriendly classmates or the danger of failing. If the parent is insistent he may go on to angry accusations, even blows. Once the parent capitulates and allows the child to remain home, relative peace is rapidly restored.

Moreover the correction of the apparent difficulty by change of classroom, reassurance of passing etc. is conspicuously unsuccessful in resolving the problem (Hersov 1985).

Commonly cited statements about school refusers as derived from the literature are as follows:

Child
The child: demanding at home; passive at home; outgoing when away from home; manipulative; slept longer than is usual (> 1 year) with parents; displays low, average, high intelligence.

Mother
The mother: emotionally deprived as child; feels incompetent in maternal role; shows signs of depression; dependent on child for companionship; lacks interest outside family; overprotective; did not desire to become pregnant; is dominant spouse; birth of the patient was feared and/or difficult.

Father
The father: dominated by family; peripheral to family affairs; ineffective in dealing with family problems; heavy drinker; emotionally deprived as a child.

Family Interaction
Poor marital relations; marriage is intact, mother and child interdependent.

School

Teacher perceived as 'mean' (in the American sense); classmates perceived as rough; school work perceived as excessive; academic performance poor; child failed at least one school year; child fears specific aspect of school; child 'acts out' at school (Atkinson et al 1989).

2.8 SUB-CLASSIFICATION

There is controversy about all aspects of school refusal; whether it is a single syndrome with a variety of symptoms or a variety of syndromes with a common presenting symptom. Several variables have been found that appear to be salient in the various sub-classifications of school refusing children. These include extensiveness of disturbance, source of fear, mode of onset, age and gender of the child.

2.8.1 Extensiveness of disturbance

The extensiveness of school refusal correlates to different variables. One variable was found in the distinctions made between Neurotic or Type 1 and characterological or Type 2 school refusal (Coolidge et al 1957; Kennedy 1965; Hersov 1960b and Weis & Cain 1964). Some correlation was also found between the mode of onset, age at onset and the extensiveness of the disturbance.

Neurotic or Type 1 children were usually found to represent the lower grades in school. The mode of onset was usually abrupt after several more or less trouble free years. Berg et al (1969) classified acute onset school refusal as an onset preceded by at least three years of trouble free attendance, regardless of subsequent duration.

At home, these children became stubborn, tense and clinging, disobedient, critical and overtly aggressive. They no longer responded to previously successful disciplinary measures. Although resisting school and difficult at home, these children's social and intellectual functioning continued satisfactorily (Coolidge et al 1957 and Kennedy 1965).

The mothers of these children were over protective, encouraged dependency and had failed to resolve their dependency on their own mothers.

The fathers were found to compete with the mothers in household management.

Wanting and fearing autonomy from their mothers, these children displaced conflict from home to school. This mechanism may well be the basis of psychoanalytic "displacement" models of school refusal.

These children were on the whole less severely disturbed than the following group to be described. They responded very well to a short term treatment programme without any recurrence of school refusing behaviour. Their prognosis also seemed to be good.

Characterological or Type 2 school refusers were prevalent in upper grades, presenting with a more insidious mode of onset.

The children were found to be more disturbed and more severely crippled than the previous group of school refusers. For the Type 2 school refuser, fear of school was merely one symptom representing a diffuse, generalized fear of the outside world. They were also timid, fearful and shy, finding it difficult to express derogatory thoughts about their over protective mothers, although there was some evidence of hostility in their behaviour toward their parents at home. Mistrusting, hypersensitive, and depressed, this group of children led a constricted life revolving entirely around the household. They also tend to have poorer pre-morbid adjustment, are more dependent on their parents, are less interested in socializing, have lower self-esteem and may be less intelligent (Baker & Wills 1978; Berg et al 1969 and Nichols & Berg, 1970).

Characterological mothers, like neurotic mothers, were overprotective, encouraged dependency, and had failed to resolve their dependency on their own mothers, but only to a larger extent than the neurotic mothers. The characterologic mothers were more dependent on their children for emotional gratification, perhaps as a result of having fewer outside

interests. They had greater feelings of inadequacy in their role as mother and were more envious and depressed.

Characterological fathers were also more disturbed, centering their lives on their child and in some cases assuming a maternal role.

Characterologically disturbed children felt such an overwhelming need to cling to mother that they had little energy left with which to approach the school situation. They may be understood best by "separation anxiety" theories.

Type 2 school refusers might be further subdivided on the basis of maternal indulgence or lack of it and the child's home behaviour. One group consisted of passive, subservient fathers and mothers who cannot set limits. It is perhaps no wonder that these children are stubborn and willful in the home. The other group consisted of demanding and impatient mothers. These children are passive and obedient at home. Both groups are inhibited and fearful outside the home (Weise & Cain 1964 and Hersov 1960b). Treatment was only modestly successful.

Extensiveness of disturbance was also subclassified according to cluster analysis (Atkinson et al 1989). Cluster (C)1 was represented by reciprocal separation anxiety, C2 by perfectionism or fear of failure and C3 correlated with Type 2 School refusers. C1 children feared separation from dependent, over protective mothers. C2 consisted of perfectionistic and depressed youngsters. They dominated mothers who had been deprived in childhood. C3 consisted of extensively disturbed children from multi problem families, who had suffer early separation or loss, and who were fearful and depressed. The mothers of C3 children were depressed and doubted their maternal competence.

Most C3 children have experienced a separation or loss. The most frequent loss was of the father, either through divorce or death. Loss was also experienced through the death of a grandparent . Grandparents are important in the lives of school refusers because often a parent has not achieved appropriate separation from his of her own parents.

2.8.2 Summary

School refusal is subclassified, based on the extensiveness of the disturbance. One group, labelled neurotic, or Type 1, school refusers is handicapped only in relation to school; their development is otherwise normal. The mothers or fathers of these children are over indulgent and too protective but not to a pathological degree. On the other hand, among the characterologically disabled, or Type 2, school refusers, fear of school is only one manifestation of an all-pervasive disturbance. These children are generally phobic and approach the world with reluctance and fear. The parents of characterological school refusers are pathologically disturbed. Characterological school refusal may take two forms. One pattern involves an overindulgent mother and a peripheral, subservient father. The child is stubborn and demanding at home. A second pattern involves a narcissistic and demanding mother. The child is passive and obedient in the home.

Three different clusters (C) of school refusers were differentiated. These are represented by C1 reciprocal separation anxiety, C2 perfectionism fear of failure and C3 extensively disturbed children. C3 correlated with Type 2 (characterological) refusers and were found to be more severely disturbed than the C1 and C2 refusers

Other variables implied in the sub-classification of school refusal; source of fear and gender, were found not to fit the Type 1 and Type 2 classification of school refusers.

2.8.3 Source of fear

Sources of fear were grouped into three major categories (Hersov 1960b and Smith 1970). The first group was composed of youngsters who presented with separation anxiety and feared harm would befall mother while at school. This fear of maternal separation is described by psychoanalysts and some learning theorists.

A second group of older children without previous difficulties at school were characterized essentially as "school phobia" patients. Although this group was "phobic" in the approach to given stimuli rather than about leaving mother, it is doubtful that it can be equated with the description by some learning theorists. These children were not afraid of the circumscribed school situation; they were generally fearful and timid. This description corresponds more closely to that of characterological, or Type 2, school refusers.

The third group consisted of older patients who seemed to be suffering from depression or fear of rejection and failure. A perfectionistic attitude and fear of failure motivated the nonattendance in some cases. The fears of these perfectionists seem similar to those discussed by psychodynamic theorists.

Based on the source of fear, (Hersov 1960b; Smith 1970 and Waldron et al 1975) school refusing children were classified according to different types.

Family interaction type refusal involved separation anxiety in the context of a mutually hostile - dependent relationship between mother and child. These children were young and feared harm would befall mother while they were at school.

Children from the situational characterological type avoided school for fear that some real situation threatened them with failure, loss of self-esteem or bodily harm. Dependence and lack of self-esteem characterized this group. These children were also older and seemed to be suffering from depression. Separation anxiety typical of family interaction type refusal was also evident in this group.

"Classical school phobia" was distinguished by the displacement of emotion from mother to school. These children, however, were older, generally phobic, even in areas other than school attendance, generally fearful and timid. They shared characteristics with characterological or Type 2, school refusers.

Various theories serve to describe the source of fear. Separating fears (disguised or otherwise) are described through psychoanalytic and some learning theory. Fear of failure and loss of self-esteem is reminiscent of psychodynamic and some learning theory. Specific fears such as fear of bodily harm is described by some learning theorists.

2.9 GENDER

Gender differences among school refusing children have been reported by several investigators. Differences in aggressiveness (Johnson et al 1941; Markey 1941, and Lippman 1962), antisocial behaviour (Adams et al 1966) and age were reported. School refusing boys were submissive and quiet whereas girls were aggressively defiant, and significantly more male than female school refusers engaged in antisocial behaviour.

Gender differences in school refusal families indicated a kind of cross-gender favouritism (Pritchard & Ward 1974). Male school refusers had over involved mothers and rejecting fathers who were in rivalry with their sons. The converse was true for female school refusers. The nature of these triadic relationships may have caused or exacerbated marital disharmony and further alienated the parent from the same sex child.

2.9.1 Summary

Different fear sources have been identified. Some children are generally fearful in their approach to life. Some are afraid of maternal separation, failure, or the school situation. There is however, much overlap between fear sources. Refusers suffering separation anxiety are likely to be more fearful in general than are other children. There are also indications that general fearfulness and extensiveness of disorder are interdependent.

Gender as a differentiating variable has indicated that the family interaction systems of boys and girls may differ.

2.10 SOCIOECONOMIC STATUS

Reports on the socioeconomic factors found in cases of school refusal are inconclusive. The correlates of social class with psychiatric disorder in childhood were also found to be weak and inconsistent. The associations with social class were found to be much less marked than those with family discord or disruption and it seems likely that it is these family features, rather than parental occupations, that matter (Wolkind & Rutter 1985).

A higher frequency of school refusers in higher socioeconomic groups were reported by Gorden & Young (1976) and Marine, (1968) whereas Berg & Hersov (1980) found a higher representation of children from poor homes. More chronic than acute refusers were from the lower social class and they also had significantly more siblings. (Baker & Wills 1978). No particular social class trend was reported by Graham (1986).

2.11 ORDINAL POSITION

Girls showed no variation but, among the boys with siblings, the last-born were significantly more likely to be seen as disliking school (7%) than were those with younger brothers and sisters (4%) (Berg & Hersov, 1980). Similar findings were reported by Graham (1986) as the "Benjamin" syndrome, where the child was perceived to be special because of being the last of a sibship. Talbot, (1957) found that more school refusers were either youngest or only children. Ordinal position, thus, seems to play a role in the development of school refusal.

2.12 FAMILY INTERACTION IN SCHOOL REFUSAL

The interaction between the child and the school will not be determined solely by the characteristics of individual and institution but the child's reaction to the school will be affected by his reference groups outside school. Of these, the family is obviously the most important, particularly at the first point of entry to the school system (Berg & Hersov, 1980).

To Skynner (1974) the essential problem in families producing seriously school phobic children can be found in the parents' failure to help their children relinquish omnipotent demands for exclusive possession of the mother. From this arose the persisting difficulties over separation from the mother and home as well as the subsequent need to establish

similar exclusive and controlling relationships either with teachers - enabling the child to cope in the "one-parent" situation of the junior school but not in the "multi-parent" environment of the senior school, or with friends - making the child exceedingly vulnerable to the loss of his/her one exclusive peer attachment.

This crucial challenge appears to be avoided by the parents. Typically the mothers maintain exclusive and possessive relationships with their own mothers until these are transferred, in turn, to their own children. Bonds between individuals are, as it were, vertical, running from parent to child, the emotional forces being essentially the same whether a given individual is in a subordinate or superior position. There is a corresponding failure to establish horizontal peer-group or genital-level bonds, i.e. mutual attachments between individuals functioning on an equal level. In such families, therefore, the primary attachments always remain between parents and children rather than between spouses.

In a normal family (Skynner, 1974) the primary attachment exists between the spouses, expressed partly by the sexual relationship but also by all the other mutual complementary inter-actions which accompany this. When a child is born, the mother needs temporarily to enter into an intense and exclusive relationship with the child, regressing to a state of what Winnicott (1956) has termed "primary maternal pre-occupation" in order to perceive the infant's needs directly through re-experiencing that stage herself. The father, if sufficiently mature, is prepared to forgo his previous unfettered enjoyment of his spouse to allow her to carry out the maternal function, while he fulfils his responsibility by "holding the life line" and supporting the mother in her biological task. An adequately mature father will, nevertheless, be prepared to forgo his normal demands on his spouse only as long as necessary and in the child's interest. All being well as soon as the child no longer needs the mother's exclusive attention, and when indeed the attachment needs to be weakened, he will automatically begin to intervene and disrupt the exclusive mother-child dyad by demanding that the mother resume her relationship with him and make her marital relationship primary again. By cutting the attachment at the mother's end the father puts the child in the position where he/she has to cope only with his/her own attachment, rather than the mother's as well, in order to escape and gain the next developmental stage.

In school phobic families, by contrast, genital primacy is not achieved by the parents; the marital relationship is weak; the father is either a peripheral figure or a dependent child, rather than a supportive and protective figure during the child's infancy; the mother-child bond remains intense throughout life and is only swung from the grandmother to the child

rather than being out-grown; and the father is typically unable to disrupt or weaken this primary attachment.

Bowlby (1973) suggested that a large majority of cases of school refusal could be understood as the product of one or more of four main patterns of family interaction.:

(a) mother or, more rarely, father is a sufferer from chronic anxiety regarding attachment figures and retains the child at home to be a companion;

(b) the child fears that something dreadful may happen to mother or possibly father while he is at school and so remains at home to prevent it happening;

(c) the child fears that something dreadful may happen to himself if he is away from home and so remains at home to prevent that happening; and

(d) mother or, more rarely father fears that something dreadful will happen to the child while he is at school and so keeps him at home.

Pattern (a) is the most common but may be combined with any of the others. In the majority of cases, mother is the principal agent but sometimes father is. (Eisenberg, 1958; Choi, 1961; Clyne, 1966 and Sperling, 1967).

Clinical experience over the years had convinced Hersov, (1985), that complaints by children and parents about any aspect of the school situation should be taken seriously and investigated as carefully as possible before discarding them as unimportant factors in aetiology and treatment. Malmquist (1965), warned against the tendency to invoke family dynamics as the sole explanation, so ignoring individual psychopathology and social experience outside the family. It seems reasonable to explore in depth the child's own perception of the school situation if one is to fully understand the reasons for non-attendance.

Parents of school refusers were also reported to present with a high incidence of psychiatric disorder, especially affective disorders.

Therefore, considering the above mentioned causative factors, school refusal is best understood as a psychosocial problem, rather than a purely intra-psychic or even intra-familial disorder.

2.13 "MASQUERADE SYNDROME"

The term "masquerade syndrome," was used by Waller and Eisenberg, (1980) to describe children whose medical problems mask their difficulty in leaving home to go to school. To detect this syndrome, the paediatrician or general practitioner must ask the parent specifically how much school the child's medical symptoms have caused him to miss, and examine the relationship between school absence and the illness.

The common thread that linked this diverse group of children was that they had all missed days, weeks, or in some instances, months of school, altogether out of proportion to that required for their medical needs. It was also found that in no case was the diagnostic significance of the fact initially appreciated, and in some, the history of school absence was not even obtained. It seemed that once a sick role had been legitimatized the possibility of the dimension of school phobia was not even entertained, despite its key role in the persistence of symptoms.

The crucial respect in which such children differ from those more commonly described as having school refusal is that the physician is not presented with an identified problem in school attendance. Rather, the following sequence of events occurs: Parents request that a paediatrician evaluate and treat their child's medical illness. The pediatrician proceeds to do this, bringing to bear the best methods available to diagnose the illness. If a psychological component is suspected, a consulting psychiatrist may be asked to evaluate the signs and symptoms. The matter of school attendance escapes surveillance, because whatever decision the child and his parents have made about going to school is seen by the child and his parents as totally appropriate to the child's illness. The child is not refusing school - he is seen as "too sick to go." The paediatrician does not initiate enquiry into school attendance, because the medical problems preempt centre stage, and behavioural aspects recede into the back-ground.

It is separation that is anxiety-producing for these parents and children not the fact that the child's attendance at school has been interrupted or curtailed. The positive developmental consequences of the child's leaving home and going to school are ignored in favour of exclusive focus on academic aspects - keeping up with school work. Regret may be expressed that the child's illness has prevented him from going to school, but this is not seen as a serious problem by either parent or child. Indeed, when a parent brings a child for medical evaluation, if both parent and child appear upset about the amount of school

being missed, one can be confident that that child does not have the "masquerade syndrome".

When the possibility of a significant school phobia dimension was called to the attention of paediatricians in these cases, they frequently protested, on the grounds that the child's symptoms were "real", since in some instances specific illnesses had been documented. The Cartesian mind-body dichotomy continues to plague medical practice (Waller & Eisenberg, 1980). The identification of organic pathology is taken as sufficient explanation of the ill behaviour. In other cases, there was a persistent fear, despite the fact that tests had so far ruled out serious illness, that something was being missed.

The question of how the physician is to diagnose and manage the underlying school phobia in the "masquerade syndrome", in a manner that properly addresses the medical aspects was proposed by Waller and Eisenberg (1980). They suggested the physician must consider objectively and separately the appropriate evaluation and follow-up for the child's medical problems and for the problems with school attendance. It was also thought necessary to stress to parents, children, and physicians that return to school would in no way diminish the carefulness of medical follow-up; the latter would simply be arranged so as not to interfere with the former. It was also found that the uncertainty of some diagnoses made it as difficult for the paediatrician to "let the child go" as it was for the parent. Once an appropriate medical out-patient plan was formulated, it became clear that there was no medical indication for further school absence.

The paediatricians treating cases presenting as undiagnosed "masquerade syndrome", were generally sceptical that the issue of school attendance had any real significance. To them, all of the children were in some sense sick, and all professed to enjoy school - rendering the diagnosis of school refusal redundant. However, the typical and recognizable features of the school refusal syndrome, began to emerge once an appropriate medical plan was formulated and return to school was advised. Plans for school return are invariably resisted. Mother and child maintained that the physical symptoms make it impossible for the child to attend. Or they predict it is certain to recur at school, making it necessary for the child to return home. Or it is suggested that since the child has missed so much school already, a further period at home would be useful to help the child "catch-up", perhaps with the assistance of a home tutor.

The masquerade syndrome was also recognized in children presenting with a chronic illness. The child who actually has a chronic life-threatening illness appears to be at a greater risk for developing the "masquerade syndrome".

Also typical of the "masquerade syndrome" is the way in which the medical symptoms of these children posed an especially difficult problem. Vague physical complaints were the presenting features of these children's school phobia dimensions, but in a child with leukemia one must always consider the possibility that the symptom is part of the malignancy (Waller & Eisenberg 1980).

The question of just how much school attendance a child is capable of, may thus be difficult to answer, especially in the late stages. Some guidelines in these cases are that, when the child withdraws from school, he misses one of the most important opportunities for socialization and independence. It is important to maintain a normal life style, including school attendance, in order to prevent emotional deterioration.

The "masquerade syndrome" will, thus, be recognized only if the paediatricians and/or consulting psychiatrists recognize the potential significance of, and evaluate properly, the matter of school attendance for every ill school-aged child.

2.14 DEPRESSION AND ANXIETY IN SCHOOL REFUSAL

Depressed mood in children with school refusal has been reported by many authors. Depression has been considered an affective symptom that may occur in any of the categories of clinical psychiatric disorder presenting as school refusal, or as the underlying disorder masked by the psychoneurotic reactions of school phobia (Hersov 1985).

Agras (1959) advanced the thesis that school phobia is part of the natural history of the depressive disorders and is but one of the modes of presentation of such disorders in childhood occurring within a depressive family constellation. Agras (1959) also suggested that either parents or child mirror the other's depression and so stimulate a regressive relationship.

Hersov (1960a; 1960b) and Davidson (1960) described depressive reactions in children with school refusal. The children were withdrawn, unable to take part in social activities, refusing to go out to an entertainment, often sitting about unable to concentrate or occupy themselves; some complained of "awful feelings" in the morning and were mildly retarded with a damping down of activity. Some of their parents also required treatment for depression. A high incidence of deaths or threatened deaths in the form of severe illness in close relatives or friends of the family also preceeded the onset of school refusal.

Gittelman-Klein and Klein (1971; 1973) treated school phobic children with imipramine. Using a definition of depression that emphasizes inability to experience pleasure and a sense of incompetence as central to the diagnosis, they found that almost all the children held the belief, unlike depressed adults, that they would miraculously recover and return to school. They therefore regard school phobic children as falling within a large group of separation-anxious children, with imipramine acting to modify this separation anxiety, thus enabling the child to return to school.

Clear-cut depressive disorders have been reported in older children and adolescents, but a depressed youngster may refuse school not only because he is lethargic and slowed down but also because of acute anxiety or somatic symptoms in the school setting, symptoms that carry specific dynamic or therapeutic implications in their own right (Warren 1965a; 1965b; Glacer 1967 and Weiner 1970). However, it is clear that the presence of depressive and or psychiatric illness is an important factor in the assessment of school refusal in all children and particularly in adolescents. Successful suicide in some children and young adolescents had presented with school refusal prior to the suicidal act (Shaffer 1974).

Affective and anxiety disorders overlap in school phobia (Bernstein & Garfinkel 1986). In children, as in the case with adults, it may be difficult to separate symptoms of depression from symptoms of severe anxiety, with symptom overlap occurring between these childhood disorders (Raskin 1984 and Hershberg et al 1982).

A large overlap was reported between patients with a diagnosis of affective disorder and patients with a diagnosis of anxiety disorder. Fifty percent met criteria for both diagnoses (Bernstein & Garfinkel 1986; Baker & Wills 1978; Davidson 1960 and Tisher 1983).

The patients clinical presentation ranged from mild to severe symptomatology. The adolescents with severe depression manifested generalized dysphoria with episodic suicidal idealism and neurovegetative symptoms. Some patients meeting criteria for anxiety disorder presented with multiple somatic complaints, panic attacks and symptoms of agoraphobia, especially in the morning when it was time to leave for school. It was often very difficult to separate the symptoms of anxiety and depression and to determine whether one disorder was primary and the other was secondary.

Significant clinical differences were found between patients with both affective and anxiety disorder, affective disorder alone, anxiety disorder alone and neither diagnosis. The patients meeting criteria for both disorders were the most symptomatic. Those with anxiety

alone or no affective or anxiety disorder were least symptomatic (Bernstein & Garfinkel 1986).

Family history studies demonstrate that affective and anxiety disorders coexist and that depression plus anxiety disorder compared to depression alone have different familial patterns. In first degree relatives of adult probands with major depression plus anxiety disorder, compared to relatives of patients with major depression alone, there is an increased risk of major depression as well as anxiety disorders (Leckman et al 1983a; 1983b). These data highlight the heterogeneity among depressive disorders and suggest that major depression with anxiety disorder may be a sub-group of depression. Perhaps chronic school refusers with both depressive and anxiety disorders represent a subgroup of affective disorders of adolescence (Bernstein & Garfinkel 1986).

2.15 SUMMARY

It is clear that there is a high incidence of overlap between affective and anxiety disorders in children presenting with school refusal. Severe anxiety disorders may also be indistinguishable from affective disorders. Different familial patterns exist in the group presenting with affective and anxiety disorders which may suggest that major depression with anxiety disorder may be a subgroup of depression.

2.16 AN ASSESSMENT AND TREATMENT PLAN IN SCHOOL REFUSAL

2.16.1 Introduction

It is evident that school refusal is a syndrome with non-uniform aetiology, psychopathology, prognosis and method of treatment. A number of psychiatric disorders accompany this emotional disturbance appearing at different ages and developmental stages during the child's school going life. Each case presents as a unique clinical problem in spite of the common themes discerned in many cases; necessitating a systematic assessment, and a planned treatment programme to effect the aims of early return to school and the alleviation of associated psychiatric disorders.

(c) The age of the child and level of maturity

These factors play an important role in the child's interaction with peers and his/her ability to cope with demands made by parents and teachers, and the anxiety created by change of school or the return to school after illness. School refusal can be precipitated by these changing situations and experiences. It is therefore important to know how earlier problems over school attendance have been handled; whether the parents insisted on school attendance or not, or if the child had been teased, shamed or punished.

(d) Personal factors of the child

It has been found that treatment plans founder if these factors are not considered seriously. These include genetic endowment, pattern of temperamental traits, personality structure, self-evaluation and level of aspiration, situations that threaten self-esteem, stubbornness and resistance to pressure and the ability to manipulate members of the family.

(e) Family factors

The child's experiences within the family, is of great importance in many cases. Included are the family methods of dealing with anxiety, anger, death, illness or other stressful circumstances. Anxiety is created in a child, if a parent (usually the mother) uses threats of abandoning the family or of committing suicide to control the child or to express anger. Such a child fears to be away from home in case something happens to his/her mother. Other important aspects - the parents' own relationship, and the position of the other family members in maintaining the family equilibrium - determine the resources that can be considered in any treatment plan. The child also responds to the general attitudes to school attendance; overt support for going to school, or hidden covert resistance that is communicated to him/her. Psychiatric disorder in a parent may interfere with his/her parenting abilities to the extent that it is impossible for the parent to exert constant control over the child. The child may also be included in the parent's symptom

pattern, rendering him fearful of leaving home to face the outside world. This can be the result of a phobic mother communicating her anxiety to her child.

(f) Examination of the child

An assessment of both the psychiatric state and physical development of the child should be made. Important factors to note are physical- and sexual-immaturity, and minor handicapping conditions, some of which may be treatable. An assessment of the child's scholastic achievements should also be made. Intellectual assessment is included to determine if backwardness contributes to the child's unwillingness to attend school.

(g) Diagnostic formulation

The importance of the formulation lies in its comprehensiveness and the constellation of clinical hypotheses about the origins of school refusal, to be tested by further enquiry if necessary and by response to specific methods of treatment. The first decision to make is whether the persistent non-attendance at school is due to truancy, withholding by parents or school refusal. If it is found to be school refusal, the extent of the condition should be determined: whether it is part of a transient adaptational reaction (most often found in younger children), a true school phobia presenting with avoidance of the classroom, or refusal based on separation anxiety. Separation anxiety may present either as a total inability to leave home or to remain alone at home without the company of the parents, or an inability to leave home to go to school while still able to visit away from home. The presence of social withdrawal, misery, loss of interest, sleep disturbance, thought disorder, abnormal perceptual experience, and falling off in school performance in older children and adolescents, should alert the investigator to the possible presence of a depressive disorder or schizophrenia. The focus of treatment sometimes need to be shifted to a parent presenting with for example, a depressive disorder. This step usually relieves the child of anxiety and responsibility, enabling him to return to school.

(h) **Problematic hypotheses**

The major factor in the school refusal is not always clear-cut. It is sometimes difficult to determine whether there is phobic avoidance to be treated by systematic desensitization therapy, separation anxiety to be treated by conjoint family interviews and systematic desensitization of the child, or a complex family pattern of separation anxiety in parents and child with mutual manipulating and reinforcement of school avoidance. The most functional hypothesis is usually selected in accordance with the response to treatment. If, in the above mentioned examples, hypotheses about phobic avoidance and depressive illness are not supported by response to effective treatment, the complex family pattern should be suspected (Hersov 1985).

2.16.3 Treatment

Treatment for these children has undergone an evolution. An early permissive procedure offered the child who refused to go to school an indefinite medical excuse to stay at home, perhaps with a home-bound teacher, while at the same time a psychiatrist and/or social worker tried to help the child and parents resolve the difficulty. Gradually the view emerged that the child's home convalescence reinforced his pathology and made his return to school all the more difficult. This recognition led to setting limits, including insistence on immediate return and concurrent treatment of the child and parents after school hours. Later, learning theory and experience showed that the level of anxiety in some children made regular and immediate school attendance impossible. A gradual weaning from home to increased contact with the school was a more realistic expectation under these circumstances. Residential treatment was also recommended for the severe cases, often that of an adolescent on the verge of a psychotic break (Marine 1968).

The onset of school refusal represents a psychiatric emergency; the longer the child stays out of school, the more difficult it becomes to return him/her (Marine 1968). A number of consequences can evolve if the child remains home: Fears concerning missed schoolwork, embarrassment with peers and teachers, secondary gain of getting extra attention at home, and the acceptance by others of his/her fears (of school) as being real. Early return is therefore necessary to prevent the phobia from becoming fixed. (Eisenberg 1959 and Suttenfield 1954).

According to traditional psychoanalytic theory long-term treatment is necessary to resolve the underlying problem causing school refusal. However, if the child is allowed to remain out of school, resistance to school builds up, which reinforces the pathology. On the other hand, if the child is immediately returned to school the underlying cause of the school refusal may never be resolved, since parents tend to lose interest in treatment as soon as the child regularly attends school (Marine 1968 and Finch & Burke 1960).

In some cases however, residential school placement or hospital in-patient treatment is necessary (Hersov 1985).

In-patient treatment is usually indicated when

(a) the child's symptoms are of such severe pathology that there is no response to other forms of treatment, and

(b) the child's disorder serves to maintain a disturbed family pattern while also gratifying the child and reinforcing his behaviour.

Admission to a unit may also ensure regular treatment in addition to the benefits of a therapeutic environment in mastering anxiety over separation experiences (Hersov 1974; 1980). The admission experience seems to actuate several dynamic mechanisms at the same time. The separation of patient and family focuses attention and affective response on the problem of pathological attachments. The child and parents need help in understanding the origins of these attachments and guidance on how to change them or else their persistence will undermine any treatment strategy; usually by parents withdrawing their child from hospital.

Admission brings the family up against the painful facts that they have failed in one of their functions which is to foster the process of separation as an aspect of healthy emotional and social development. It also exposes them to the precise situation that they were avoiding (Hersov 1985).

Different pharmacotherapeutic agents were also used in the treatment of school refusal. Imipramine proved to be effective in facilitating return to classroom, probably by modifying the child's level of separation anxiety. (Gittelman Klein & Klein 1971, 1973 and Hersov 1985). Clomipramine had no effect on separation anxiety, other neurotic symptoms or depression (Berney et al 1981). Sulpiride produced an improvement in a substantial number of cases (Abe 1979).

Anti-depressant medication alone is highly unlikely to significantly influence the more entrenched emotional and family problems. Medication may complement the effects of other therapeutic measures in the treatment of school refusal where there are specific indications for its use.

The following four basic steps form an essential part of any overall treatment approach:

(a) establishing a good, trusting relationship with the child and his family;

(b) clarifying the stimulus situations which gives rise to anxiety (at home or at school);

(c) desensitizing the child to feared situations by using imagination, relaxation or merely talking, whichever is appropriate; and

(d) confronting the feared situations (Yule et al 1980; Hersov 1985 and Miller et al 1974).

Various procedures to return children to school were developed by different researchers.

The successful return of children presenting with mild neurotic school refusal were based on the following steps:

(a) Maintenance of good public relations so that doctors, teachers, and parents refer cases as soon as possible.

(b) Avoidance of emphasis on the child's inevitable complaints of feeling sick. (Parents are instructed to deal with these in a matter-of-fact way by arranging for a medical examination outside school hours).

(c) Requiring the child to go to school, and being willing to use any force necessary. (The father takes the child to school, and the principal or attendance officer takes an active part in keeping the child in the room).

(d) An interview with the parents, in which the therapist is optimistic and outlines a plan of attack. (Parents are asked not to discuss the refusal with the child, but simply to announce that the child will be returning to school the following day. On the next morning, the child is dressed and taken to school, regardless of his reaction. In the evening the child must be complimented on staying in school even if for only thirty minutes and under protest. On the following two days the procedure is repeated. On the evening of the third day, which is usually symptom-free, parents should give a party for the child for overcoming his problem).

(e) An interview with the child, always out of school hours, when the therapist relates stories of heroes conquering fear.

(f) Follow-up by telephone, with a manner that is chatty, encouraging, and not oversolicitous (Marine 1968 and Kennedy 1965).

The main principles of a group-analytic approach to conjoint family therapy

are as follows:

(a) At least the whole nuclear family, including the father and siblings, are included in the interview, as well as any other figures who appear to have a crucial influence.

(b) The focus is on the family interaction, the 'here and now' of the interview, although past history is included when it emerges, as it tends to do at appropriate moments.

(c) As will be evident, there is a particular focus on non-verbal communication. Making this explicit and thereby confronting the family with its hidden system or rules and attitudes constitute the main interventions. Interpreting the intra-psychic dynamics is largely unnecessary because, as Beels and Ferber (1969) have pointed out, the non-verbal system is a direct expression of much that is signified, in another frame of reference, by the term 'unconscious'.

(d) The exploration is directed towards discovering the developmental stage the parents have been unable to help the child transcend, and towards both presenting, and giving help in mastering, this developmental challenge.

(e) It has been found that there are clear advantage in using a very few widely spaced interviews - often only one (excluding follow-up) - since this increases the sense of responsibility felt by the family for tackling the problem themselves; limits the displacement of transference attitudes from family members on to the therapists; and if a group-analytic technique is used (which facilitates therapeutic interaction between family members rather than focusing it on the therapists) ensures that most of the working through will be carried out in the home situation.

(f) Where possible, change is achieved by increasing insight and understanding through interpretation, enabling the family itself to supply the skills and resources it lacks. Where this does not appear possible, however, the therapist either supplies the missing parental

functions through his own responses, or arranges for them to be provided by some other agency outside the family (social worker, club leader, court etc.) (Skynner 1974; 1969).

A crude classification of school refusal with its treatment implications is as follows:

(a) A manifestation of separation anxiety is usually found, where school refusal shows at first entry to school. The parents inability to handle their child firmly and consistently may well complicate the situation. Some form of in-vivo desensitization exercises seems the most appropriate initial approach.

(b) A major change of schooling around the age of 12 years was associated with many cases of school refusal. One such change is from the smaller, more child-centered form of primary schooling to the larger, less personal secondary school. Other stresses experienced by some vulnerable children at transfer included the bright child coming up against real competition for the first time, and the transition from being the eldest in the primary setting to being the youngest in the rougher secondary setting. An episode of school refusal resulted in cases where the particular school stress experienced, was sufficiently compounded by the addition of any extraneous threat such as a personal experience of illness, or illness or death of a family member, or the loss of close friends. The approach of choice, in these cases, is systematic desensitization and paying attention to details of the physical and social environment. A graded re-entry to school should be effected relatively quickly.

(c) In older children, who managed to attend school regularly for 9 to 10 years, non-attendance may well be associated with the onset of a depressive illness or even an early onset schizophrenia. The older child, in all cases of treatment, must be involved more individually than is often necessary with younger children. This opportunity can be used to teach the adolescent better coping skills, instead of always avoiding difficult situations.

(d) Straight forward techniques are likely to be successful very quickly, where children of any age have been out of school for a very short time, usually less than two weeks. Schools should, thus, be encouraged to recognize school refusal early as such secondary preventative work makes for easier therapeutic intervention.

(e) Children who are already afraid of separating from home are more sensitive to specific incidents at school such as bullying or ridicule. Whilst this appears to lead to more breakdowns in attendance at the time of school transfer, it can happen at any time. Children, 10 to 13 years old, are in the developmental stage where they begin to realize death is both universal and irreversible. Their fear may well be exacerbated, should there be a reality based incident. If the situation is not properly handled by the parents, the child may well stay at home to be near them. Therefore, when school refusal is recognized, whatever the age of the child, it is advisable to enquire into the child's history of separations and his recent experiences of death (in family, friends, or even pets) in more detail than usual, as well as whether a parent has threatened to leave home or commit suicide or whether such behaviour has occurred (Yule et al 1980).

Conclusion

Treatment programmes, to be most successful, should include all parties concerned (parents, child, school personnel, social worker etc.) in planning the child's return to school. The older the child the more his involvement should also be sought (Lassers et al 1973 and Talbot 1957).

2.17 OUTCOME

Treatment outcome is usually good whatever form it takes. Success rates vary from 100% to 36% with a usual success rate of two-thirds or more (Hersov 1960a, 1960b; 1985; Kennedy 1965; Davidson 1960 and Coolidge et al 1964).

The prognosis, on the other hand, seems related to the severity of the disorder, age of the child, and time between onset of symptoms and beginning of treatment. A poorer prognosis was found with children over the age of 11 years, a 36% success rate as against the 89% success rate in return to school in children under the age of 11 years. The findings suggest that more severe pathology is found in the older children and their families (Coolidge et al 1960 and Rodriquez et al 1959).

Cases admitted to hospital also tend to be older with symptoms of longer duration, greater severity and resistance to out-patient treatment. Follow-up after hospital treatment, reflected that one-third had persisting severe emotional disturbance and social impairment; one-third had improved to a considerable extent although still suffering from emotional symptoms; and a further third were almost completely free of problems. In about one-half, school attendance problems had persisted but later work problems were less frequent. High intelligence appeared to be associated with a poor outcome (Berg et al 1976).

School refusal, particularly in adolescence, occurred significantly more often among psychiatric patients and it is concluded that some children who present with problems of school refusal are at risk for psychiatric disorder in adult life, (depressive illness, schizoid personality traits, schizophrenia and obsessional disorder) but that most school refusers will become normal adults (Tyrer & Tyrer 1974 and Berg et al 1976).

Adult outcome of school refusal revealed that most were able to draw away from their families, but social contacts remained limited and those who married were very dependent on their husbands. Difficulties present in early adulthood stabilized toward middle life, although one third showed evidence of current "neurotic" problems. Agoraphobia with an early onset occurred in a very small number of subjects as part of a more general neurotic tendency (Hersov 1985 and Nursten 1963).

2.18 CONCLUSION

School refusal constitutes a symptom complex appearing in more than one psychological configuration. A diverse blend is found of developmental factors and intra-psychic conflicts in the child, imbalance in family relationships, social forces in the child's environment, and intrinsic school factors.

The treatment philosophy has evolved from a permissive procedure of allowing a child, presenting with a reluctance to attend school to remain at home until the problem was resolved, to the application of methods of psychotherapy, family therapy, behaviour therapy, milieu therapy, and pharmacotherapy, in various combinations in the context of out-patient, day-patient or hospital in-patient treatment.

Outcome of treatment was usually successful in two-thirds or more of cases. Several prognostic indicators were found together with a small percentage of school refusers at risk for psychiatric disorder in adult life.

PART II - THE RESEARCH STUDY

CHAPTER 3 - RESEARCH DESIGN

3.1 INTRODUCTION

The research design is that of a descriptive survey. Descriptive comes form de-, meaning "from", and scribere, "to write". The word survey is derived from the Latin and means "to look over or beyond". As the name suggests, a descriptive survey is therefore concerned with description rather than explanation. The purpose of a descriptive survey is to describe events or phenomena in order to gain knowledge of the condition under investigation (Leedy 1989; Wicks-Nelson & Israel 1984 and Haralambos & Heald 1980).

3.2 RESEARCH DESIGN

The research design chosen for this study consisted of the Descriptive survey method supplemented by systematic random sampling. This design best suited the intention of this study; to describe specific aspects of school refusal without attempting to explain any particular aspect under investigation.

Some advantages of the descriptive survey method in spite of its essentially simple design, lie in the effective application to sophisticated and less sophisticated research designs. Data are reported verbally and the means to elicit the data are verbally oriented; written records and questionnaires. Conclusions are drawn in words from all the recorded words with the application of calculations to a limited extent only. The sampling method offered the best opportunity for the study sample to be representative of the study population.

This research design is subject to shortcomings. Descriptive studies, to be effective, have to be systematic in design and comprehensive. This tends to make these studies lengthy and time consuming. The sampling also needs to be without systemic bias. Application of data analysis is restricted through the limitations imposed on generalizations drawn from the analysis.

The study, investigating various aspects of school refusal, was constructed from all cases seen over a three year period at the Child and Family Unit, Red Cross War Memorial Children's Hospital.

Referrals to the Unit originate from various sources. Cases referred as "school refusal" are viewed as urgent referrals and dealt with accordingly. A principal therapist is appointed, who has access to either a multi-disciplinary team or individual supervision to assist with the case management. Individual members of the multi-disciplinary team can assist with the management as co-therapists.

The initial interview is arranged to include the nuclear family and other persons of importance involved with the case (members of the extended family, friends etc.). The importance of the father's presence during the first interview is emphasized during the initial arrangements. The assessment includes an evaluation of

(a) the child's physical and psychiatric state;

(b) the family functioning;

(c) the psychiatric state of other family members; and

(d) additional contributing or precipitating factors in the child's social and school environment.

The assessment is supplemented with reports from the school, psychometric evaluation (as indicated) and referral to the out-patient section of the Red Cross Children's Hospital. The latter was only undertaken if a thorough physical examination had not been performed prior to the referral. Briefly, the management entailed different combinations of the various methods of treatment described in chapter 2.

The required data were documented in a retrospective manner, facilitated by a 15 point questionnaire (Appendix 1).

The sampling type used in this study on School Refusal was systematic random sampling.

The population consisted of 1031 children referred to the Out Patient Section of the Child and Family Unit, Red Cross War Memorial Children's Hospital, during the 3 year period July 1983 to June 1986. This particular time period was chosen firstly to fit in with the retrospective nature of the study. It was also estimated that none of these cases would still be in treatment at the time the sample was drawn in 1987. The second reason was to secure a large enough study sample. With an average of 343 referrals per annum and an overall clinical incidence of 5% of all children referred for psychiatric disorder (Hersov 1985), 17 cases referred because of school refusal were expected to have undergone treatment. The number of cases seen over a 3 year period would then have produced a sample of 51 cases. For inclusion the cases had to fulfill at least the 1st, 2nd and 4th criteria, suggested by Berg (1980) as follows:

1. Severe difficulty in attending school usually amounting to prolonged absence.
2. Severe emotional upset when faced with the prospect of going to school, including excessive fearfulness, undue tempers, misery, and complaints of feeling ill without an organic cause being found.
3. Staying at home with the knowledge of their parents when they should be at school.
4. Absence of significant anti-social disorders such as stealing, lying, wandering and destructiveness.

Because much information was taken from clinical files where all criteria were not easily verifiable, cases were included if the 3rd criterium could not be verified.

The resulting stratum comprised of 65 cases selected from a population of 1031 cases. Systematic random sampling was then used to select the 20 cases, representing the sample size.

CHAPTER 4

RESULTS

The study sample comprised 20 cases (N = 20), 11 boys and 9 girls.

Race	Gender Male	Female	Age
Asian	0 1 (5%)	0 0	5 - 8 years 9 - 13 years
Black	0 0	0 0	5 - 8 years 9 - 13 years
Coloured	0 8 (40%)	1 (5%) 4 (20%)	5 - 8 years 9 - 13 years
White	0 (0%) 2 (10%)	0 4 (20%)	5 - 8 years 9 - 13 years

Table 4.1 *Race, age & gender distribution (Frequency and percentage)*

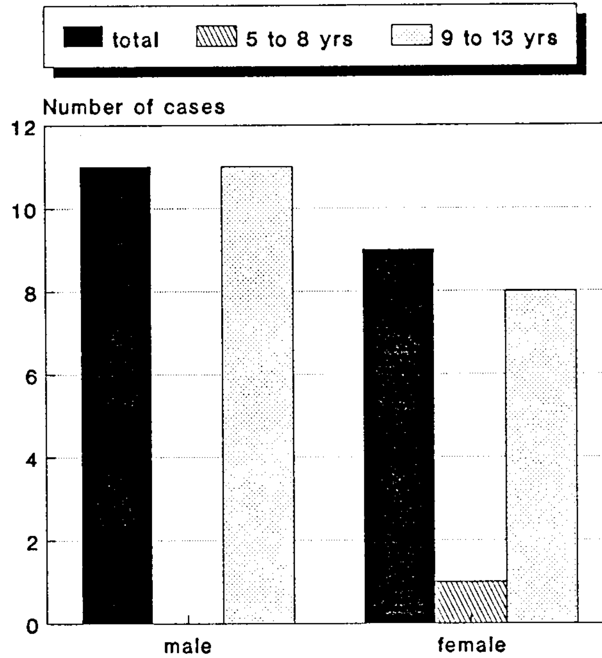

Figure 4.1.1 Grouping by age

Divided into 2 age groups, no boy was grouped in the 5 - 8 year age group with 11 boys in the 9 - 13 year age group. Of the 9 girls, 1 girl was grouped in the 5 - 8 year group and 8 in the 9 - 13 year group (Figure 4.1.1).

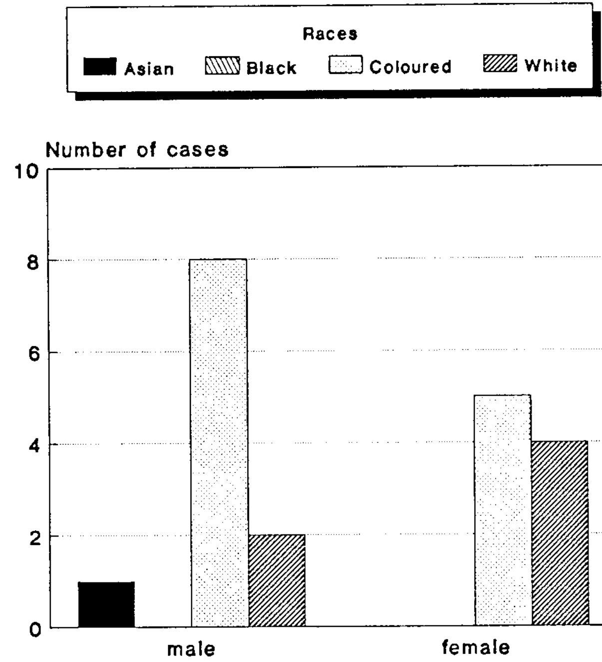

Figure 4.1.2 Grouping by race

Classified according to race, 1 case fell in the Asian, 13 cases into the Coloured and 6 cases into the White race groups. None of the cases fell into the Black group (Figure 4.1.2 and Table 4.1).

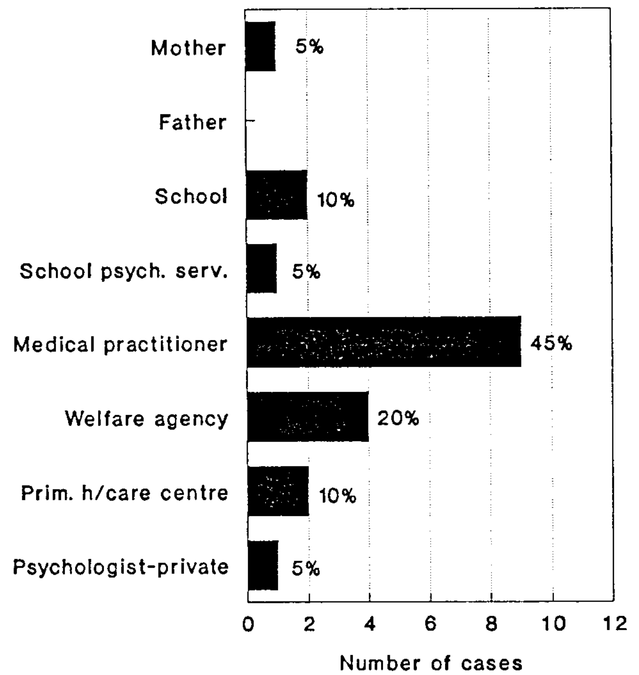

Figure 4.2 *Referring agents*

Referrals originated in 9 cases from a medical practitioner, in 4 cases from a welfare agency, in 2 cases each from the school and the primary health care centre, and in one case each from the school psychological services, a mother and a psychologist in private practice (Figure 4.2).

SCHOLASTIC ACHIEVEMENT

Age group	1 Standard failed		2 Standards failed	
	Male	Female	Male	Female
6 - 9 years	-	-	-	-
10 - 13 years	1 (5%)	2 (10%)	2 (10%)	1 (5%)

Table 4.3.1 Educational factors

The number of children who had failed one or more classes was 6 in total. Of these, 3 children had failed one class only and three had failed 2 classes. Two girls and one boy had failed one class each whereas 2 boys and 1 girl had failed 2 classes each (Figure 4.3 and table 4.3.1).

Total IQ scores were obtained from 8 (40%) of the 20 cases. The scores ranged from 57 to 108 with a mean score of 83. Only one total IQ score of 108 was within the limits of the average IQ category (90 - 110). Three of the IQ scores fell in the below average category (81 - 89), one in the borderline category (71 - 80) and 2 in the mild mental retardation category (50 - 70) (table 4.3.2).

INTELLECTUAL ASSESSMENT

	N	%
50 - 70	2	10
70 - 80	1	10
80 - 90	4	20
90 - 110	1	5
No IQ score	12	60

Table 4.3.2 I.Q. Scores (Frequency percentage)

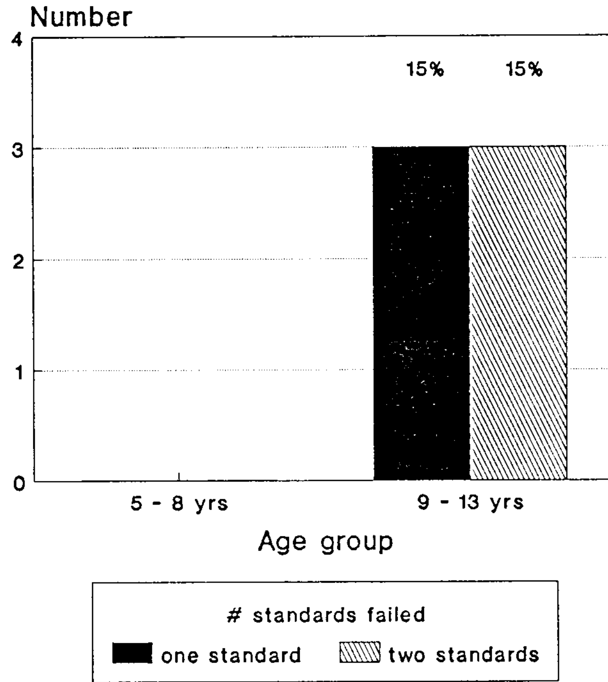

Figure 4.3 *Standards failed*

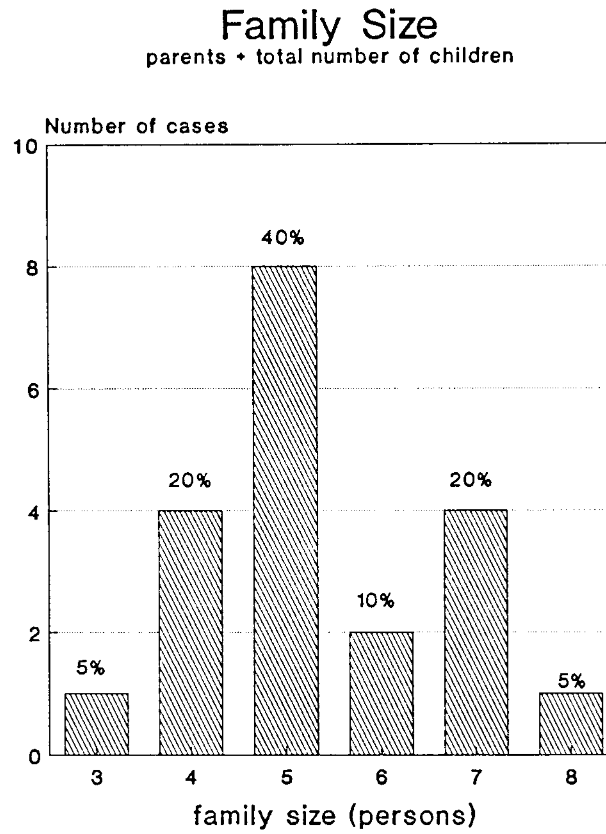

Figure 4.4 *Family size*

The family sizes were as follows:

A father was present in all but one family (N = 19), a mother was part of the family in all the cases (N = 20). The number of siblings ranged from the child referred being the only child to the child referred having 5 sibs. The majority of the families (N = 15) consisted of 4 children or less. Four of the families consisted of 5 children and one family of 6 children (Figure 4.4).

Factors involving the parents more directly are outlined in figure 4.5. These include the ages of the parent, (figure 4.5.1) their level of qualification (figure 4.5.2) and their occupation (figure 4.5.3) as described in appendix 5.

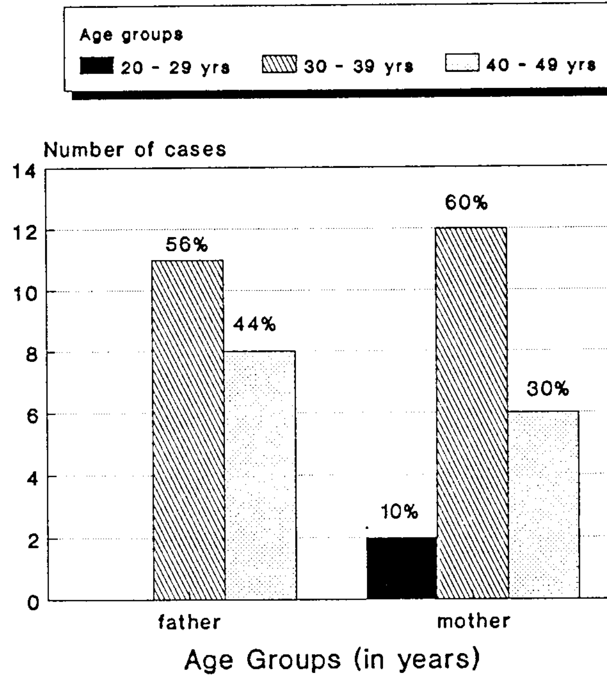

Figure 4.5.1 Age of Parents

Of the fathers, 11 were in the age group 30 -39 and 8 in the group 40 - 49. Of the mothers, 2 were in the age group 20 - 29; 12 in the group 30 - 39 years and 6 in the group 40 - 49.

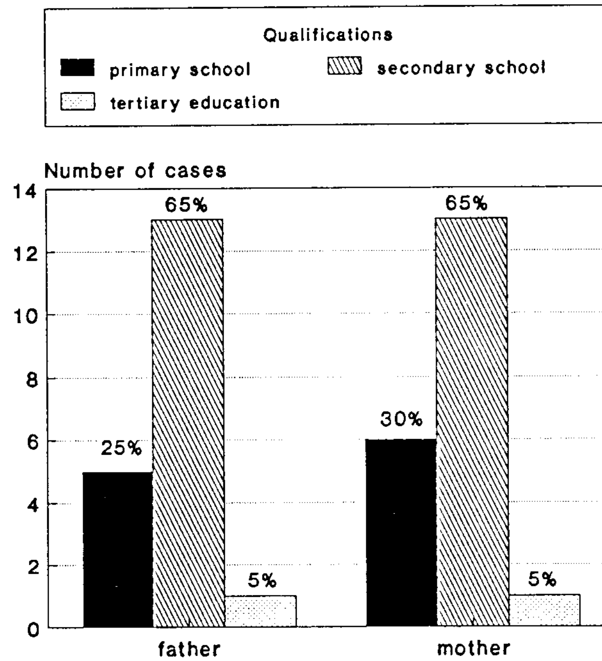

Figure 4.5.2 Parental Qualifications

The parents' highest level of qualification ranged from a standard 3 (primary school) to a tertiary education. The distribution of the qualifications of the fathers and the mothers are outlined in Figure 4.5.2.

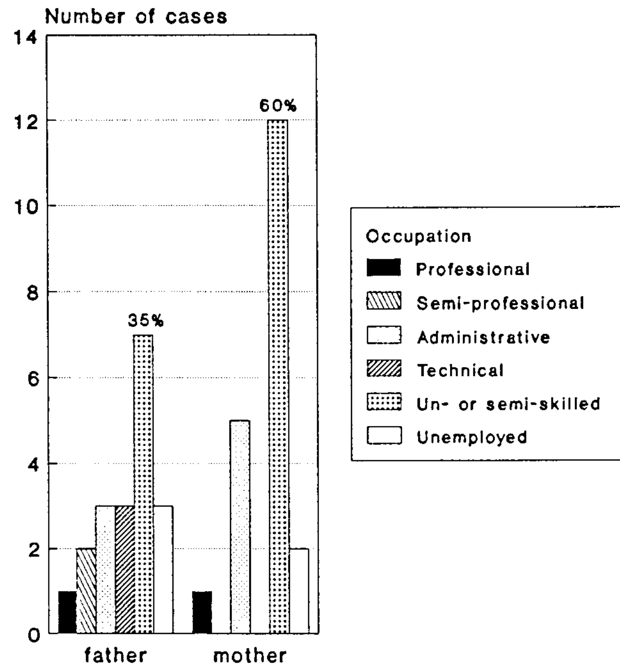

Figure 4.5.3 Parental Occupation

Parental occupation is organized into 6 major categories as explained in Appendix 5. The categories are

1. Professional
2. Semi-professional
3. Administrative
4. Technical
5. Unskilled/Semiskilled
6. Unemployed.

Seven of the fathers were employed in unskilled or semi-skilled positions, 3 each in an administrative or technical post, 2 were employed as semi-professionals and 1 in a professional position. Three of the fathers were unemployed. The mothers' employment

was 12 in unskilled or semi-skilled posts, 5 in administrative, one in a professional post. Two of the mothers were unemployed.

The marital status of the parents (Appendix 1) consisted of 15 being married, 2 divorced, 2 single mothers - 1 never married and 1 widowed, 1 mother and father were separated and living apart, and 1 divorced mother was cohabiting.

Duration of School Refusal

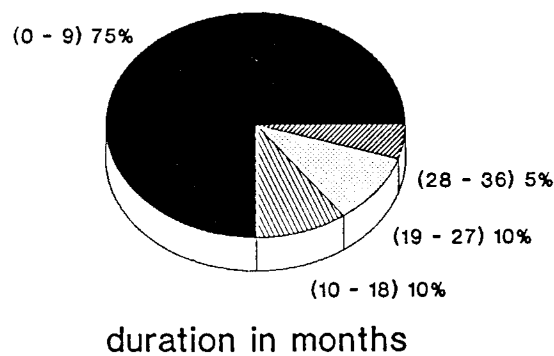

Figure 4.6.1 Period of absence from school

The duration of refusal to attend school varied from one month or less to as much as 36 months in a single case. A duration of 9 months or less was evident in 15 of the reported cases. One case each presented with a duration of 12, 13, 19, 20 and 36 months respectively (Figure 4.6.1 and 4.6.2).

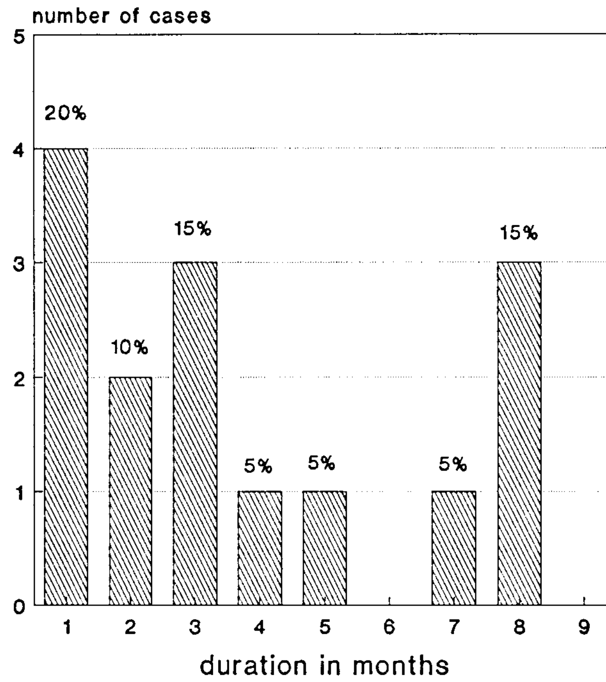

Figure 4.6.2 Period of absence from school (= 9 months)

Previous episodes of school refusal of unknown duration were also recorded in 8 cases.

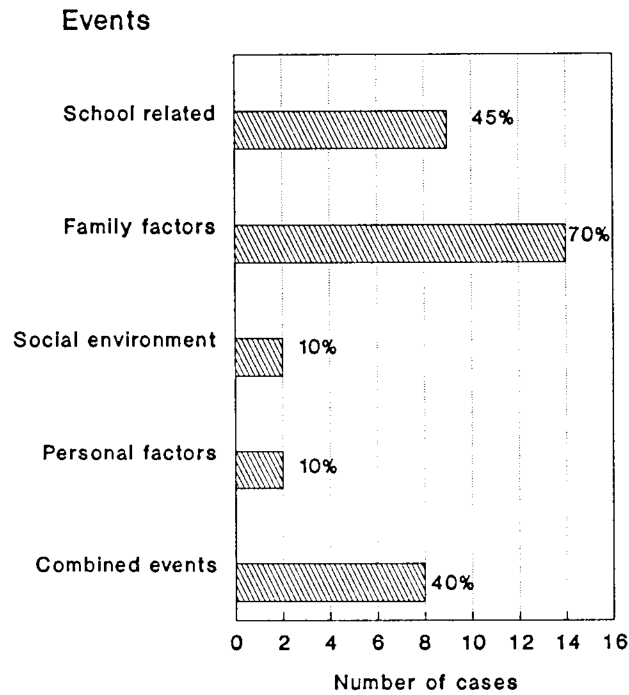

Figure 4.7 *Associated events*

Significant associated events as outlined in appendix 3 were recorded in 18 of the 20 cases. Nine of the events were school related, 14 were family oriented, 2 were due to environmental factors and 2 to personal factors. Different combinations of these events were evident in 8 of the cases (Figure 4.7).

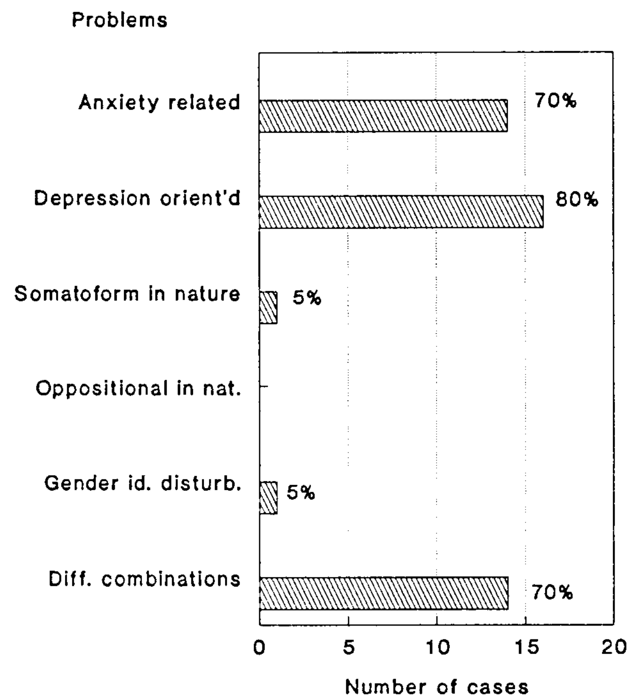

Figure 4.8 *Additional presenting problems*

Symptoms or problems other than school refusal as explained in appendix 2 were evident in all cases (N = 20). Anxiety related symptoms were present in 14 cases, symptoms of depression in 16 of the cases, with an overlap of these two symptoms in 10 cases. One case each presented with symptoms relating to a somatoform disorder and a gender identity disorder (Figure 4.8).

Family function was recorded in accordance with the McMaster Model of Family functioning (Epstein & Bishop, 1981). Nineteen of the 20 families were recorded to be dysfunctional families (Appendix 4).

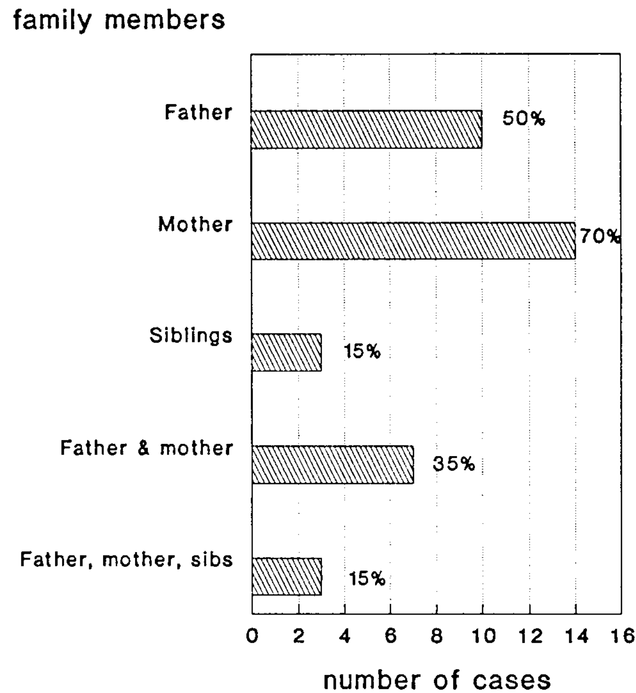

Figure 4.9 *Psychiatric disturbance in family*

Evidence of a psychiatric disorder in the parents and siblings of the referred child was also recorded. It was not possible always to come to a clinical psychiatric diagnosis because much of the information was taken from clinical files where criteria were not always easily verifiable. The presence or absence of a recognizable psychiatric condition was therefore recorded either as Yes or No. Fathers identified as explained were 10 in total. Mothers numbered 14 and sibs 3. Both parents presented with a recognizable psychiatric condition in 7 of the 20 cases. Both parents and a sibling qualified in 3 cases (Figure 4.9).

Diagnostic categories as explained in Appendix 6 were recorded as follows.

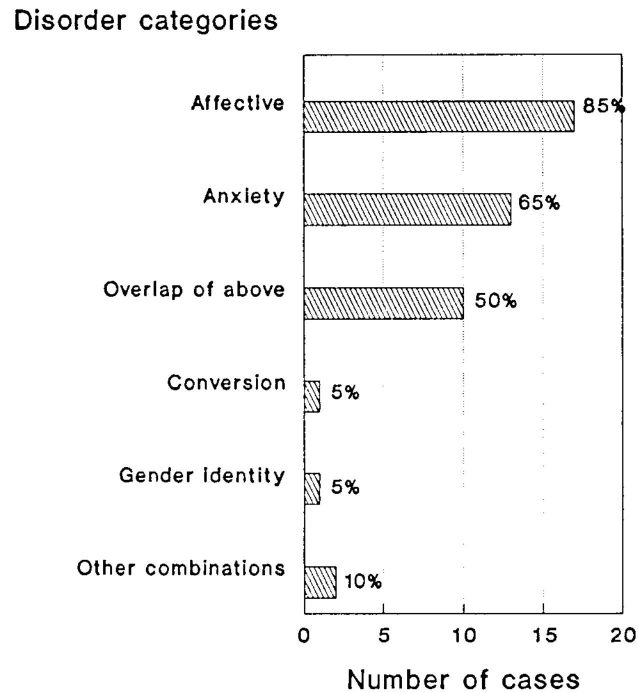

Figure 4.10 Diagnosis

Anxiety disorders were diagnosed in 13 case, affective disorders (depression) in 17 cases. An overlap of anxiety and affective disorders was found in 10 cases. One diagnosis of conversion disorder was recorded as well as one diagnosis of a gender identity disorder of childhood. Depression was also diagnosed in each of the cases diagnosed as a conversion and gender identity disorder (Figure 4.10).

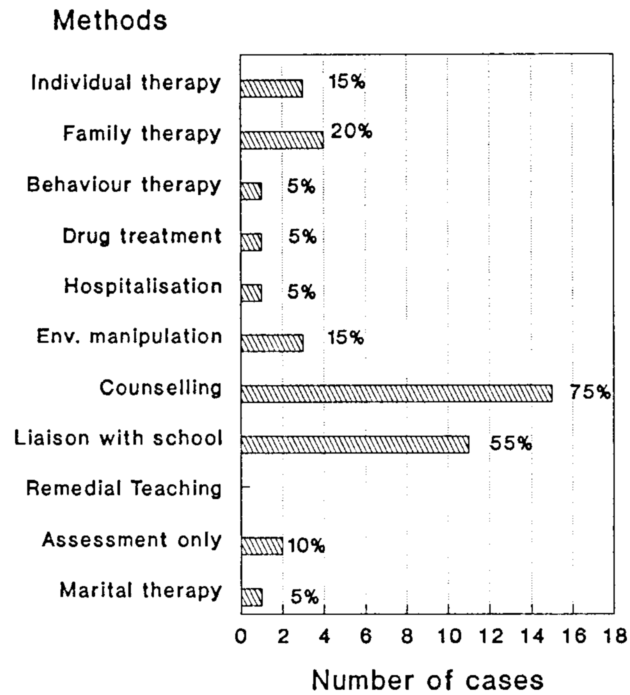

Figure 4.11.1 Treatment

Methods of treatment used in this study are outlined in Appendix 1. A combination of methods were used in 14 cases. A single method of treatment was used in 6 cases (Figure 4.11.1 and 4.11.2).

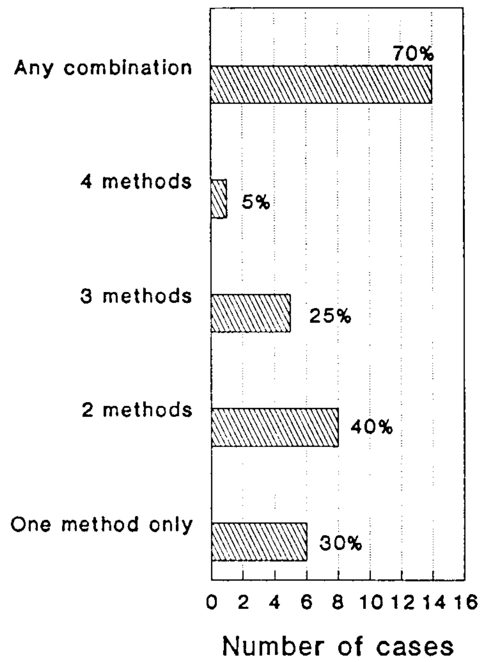

Figure 4.11.2 Combination of treatment methods

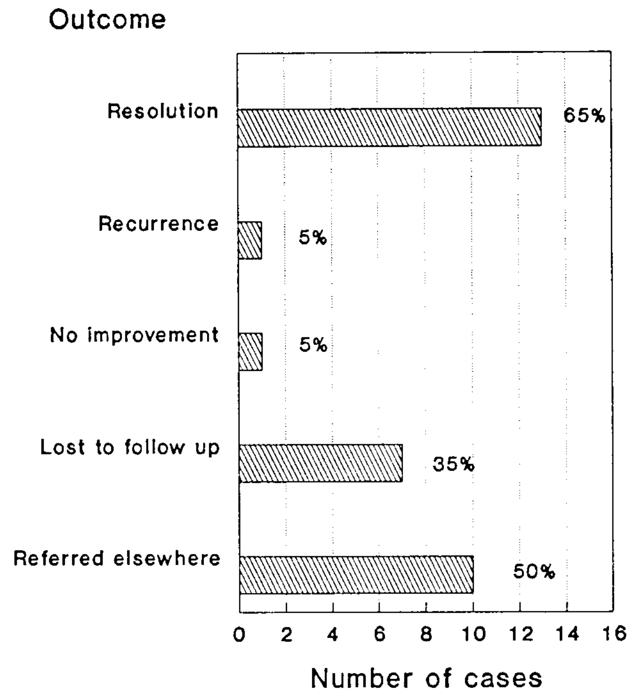

Figure 4.12 Response to treatment

Resolution of refusal to attend school was effected in 13 of the 20 cases. Recurrence of school refusal occurred in one case and seven cases were lost to follow up (Figure 4.12).

CHAPTER 5

5. DISCUSSION OF RESULTS

5.1 INTRODUCTION

"Research reports should present the statistical data, a narrative of findings, and an interpretation of what the findings mean and what decisions may be taken based on them." (Backstrom & Hursh-César, 1981). The aim of report writing is to communicate, not to impress.

The research design, method of sampling and data analysis were discussed in more detail in Chapter 3. All the data from the different case reports were analysed according to the same methods.

This chapter presents an outline and a discussion of the results obtained from the study.

Results from this study were obtained from a clinical population and not from a general population of children. Any conclusions drawn from the results will therefore refer only to the particular sample studied. Similarly any recommendations will also apply only to the Child and Family Unit and not to all cases of school refusal.

5.2 DISCUSSION OF RESULTS

5.2.1 Identifying data

The sample of 20 cases consisted of 9 girls and 11 boys which almost represents an equal distribution as reported by Kennedy (1965) and Graham (1986).

The 2 age groups used also corresponded with 2 of the 3 peak ages for occurrence of school refusal. The 3 peak periods of school going-age are between the ages of 5 and 7 years; at 11 years; and again at 14 years and older (Hersov 1985). The majority of the children consisted of the middle

age group (9 - 13 years). The small number of younger children reported in this study most likely reflects the result of successful treatment elsewhere. A higher prevalence rate was also reported in early adolescence and secondary schools than in infant or primary schools (Hersov 1985).

The 4 major population groups were represented by 1 Asian child, 13 Coloured children and 6 White children. No Black children were reported by this particular study. This finding is not an indication that Black children do not present with school refusal. The non-representation of Black children in the study can be due to a too small sample size as well as a possible indication of the relatively inaccessibility of the service to the Black community. The latter reason can be the result of an interplay of different factors some of which can be the geographic location of the Child and Family Unit; prevailing socio-economic conditions within the Black communities, and the fact that schooling is not compulsory. The chances of Black children being represented by a study with such a small sample size is further restricted by a tendency for Black school refusing children to be less well represented at clinics as reported by Adams et al (1966) and Heath (1983) in Hersov (1985). Rutter et al (1974) also reported a low figure for school non-attendance among 10-year old West Indian children in an inner London borough.

5.3 SOCIO-ECONOMIC FACTORS

Prevailing socio-economic factors were portrayed by the qualifications and occupations of the parents. The occupations of the parents were divided into 6 categories (Appendix 2). It is clear from these findings that the majority of the children were representative of the lower socio-economic group. These findings are in accordance with the findings of Hersov and Berg (1980) who reported a higher representation of children from poor homes. These findings also indicate that school refusal is not a disorder associated with a specific socio-economic group only, but that it represents different socio-economic groups.

Previous classes failed was taken as an indication of educational problems. According to this criterion, slightly less than a third of the sample (30%) experienced scholastic difficulties as they failed one or two classes prior to the referral. The majority of children (70%) however, experienced no academic

problems. Berg (1980) reports on different findings by different researchers. Some studies reported little evidence that educational difficulties are at all common in school refusal although some youngsters with this condition undoubtedly have problems with school work. Other reports, however, suggested that such difficulties may not be as uncommon as previously supposed. One study reported that 50% of school refusing grammar school children had serious educational problems. These findings support the results of this study. These findings also reflect on the role school factors play in the origin of school refusal.

Total IQ scores were obtained from 8 (40%) of the 20 cases. These findings are in sharp contrast to the reported mean total IQ scores of 117 and 121, found in primary schools as reported by Berg (1980). An explanation for this difference can be found in the majority of the cases reported in this study being representative of the lower socio-economic group and larger families. The majority of their parents also held low academic qualifications. These are known factors that adversely affect the IQ scores and academic achievements of children growing up under the influence of these conditions. It is also possible that the children with higher IQ's were not tested because there was no question of a low IQ.

5.4 FAMILY FACTORS

The recorded cases tended to come from larger dysfunctional families of low socio-economic status. Family discord has been reported to have a stronger association with child psychiatric disorders than has social class (Wolkind & Rutter 1985). The high recorded incidence of family dysfunction in this study (95%) was likely a more significant factor in the development of school refusal than the socio-economic status of the family. A dysfunctional family can also not fullfil its important mediating role between the child and the school environment which can further contribute to the development of school refusal.

Only 2 of the recorded mothers were relatively young, most likely because the majority of the children were grouped in the 9 - 13 year group and were from larger families. Age differences between parents with fathers being older than mothers can be the reason why no father was grouped in the 20 - 29 age group. No mention was made about parental ages in the literature reviewed. The significance of the ages of the parents can not be determined because of the small size of the sample.

5.5 SOURCES OF REFERRAL

Analysis of the sources of referral can be an indication that a large percentage of the children presented initially with physical complaints described by Waller and Eisenberg (1980) as the "masquerade syndrome". Physical symptoms were also described as the negative concomitants of anxiety by various researchers. The relatively few cases referred by the schools is in keeping with Farrington's (1980) findings that teachers attributed poor school attendance mainly to illness. Another reason why teachers may be reluctant to refer non-attenders, is that they may experience the non-attendance as rejection, creating feelings of guilt and anxiety (Jones 1980). Should these be valid factors, school personnel must then be informed as to the true "nature" of school refusal and the different means of presentation.

5.6 CLINICAL CHARACTERISTICS

The majority of the recorded cases qualified as "acute" cases of school refusal according to the distinction proposed by Berg et al (1969): If there had been 3 years of trouble-free school attendance before the school refusal began, the case was classified as "acute", however long the condition continued subsequently. The significance of this "acute" classification will be indicated in the section on treatment outcome.

Significant associated events that could have influenced the onset of school refusal were present in 90% of the recorded cases. The significance of associated events to the onset of school refusal were reported by various researchers. (Marine 1968; Hersov 1985; Hersov 1980 and Yule et al 1980). Family related events were once again found to be the most important contributing factor to the development of school refusal.

Presenting symptoms or signs other than school refusal were evident in all the recorded cases. Symptoms most prevalent were indicative of either an anxiety- or an affective disorder. A variety of physical symptoms (stomach aches, headaches, vomiting, leg pains, etc.) were present as the vegetative concomitants of anxiety or as the vegetative components on an affective disorder.

It is clear from these findings that refusal to attend school was only one symptom of a symptom complex in which symptoms of anxiety and depression were most prevalent (Atkinson et al 1989; Sperling 1967 and Marine 1968).

An overlap of affective and anxiety disorders in 50% of the cases found in this study, was also reported by Bernstein et al (1986). Affective disorder was more frequently diagnosed (85%) than anxiety disorder (65%). This tendency was also reported by Bernstein et al (1986) as well as a comment that depression in association with school refusal may be more common in older children refusing to attend school. The majority of the children in this study (80%) were grouped in the 9 - 13 year age group. This could possibly explain the relatively higher incidence of affective disorder in this study.

5.7 TREATMENT

A combination of treatment methods was utilized in 14 out of the 20 cases treated. The most often used method either as the sole method of treatment or in combination with one or more of the other methods, was counselling. This included family, parental or marital counselling. Only one case was admitted for treatment as an in-patient to the Red Cross Children's Hospital. This is an indication that the majority of children presented with a less severe form of school refusal that was responsive to other forms of therapy. The family pattern was also not so severely disturbed that it reinforced the school refusing behaviour (Hersov 1980). There was little need to bring environmental changes about as this was indicated in only 3 of the 20 cases. Environmental manipulation in this study included a change in residence and/or school. This particular aspect is in keeping with Hersov (1980) who reports that a change of school or class should only be undertaken for a valid reason such as a need for a small school, a school with less stringent academic demands etc. It is also generally agreed upon that the treatment programme should actively involve the child, the parents, school personnel and the representative of the local social agency, to bring about the best possible response to the treatment plan. The school personnel were included in only 55% of recorded treatment plans which could indicate that the school environment was not highly valued as a contributing factor in either the cause or treatment of school refusal.

Liaison with the schools in this study meant the school personnel concerned were included as members of the treatment team to implement the treatment plan. The characteristics of

school refusal were discussed as well as any causative factors found to have originated in the school environment.

Remedial teaching was not used as a method of treatment because the children in need of remedial teaching were most likely receiving remedial teaching at their schools or local school clinic.

The two cases that received assessment only, were referred from up-country for a multi-disciplinary team assessment and suggestions on treatment plans.

5.8 OUTCOME

Referring to this study, successful return to school was affected in 13 out of the 20 cases, a success rate of 65%. This is much less than the 100% success rate reported by Kennedy (1965) but midway between the success rates of 36% and 89% reported by Rodriquez et al (1959) as found in their study of children above and below age 11 years respectively and in line with the usual success rate of two-thirds or more (Hersov 1960a, b; Davidson 1960 and Coolidge et al 1964). Seven of the 20 cases (35%) were lost to follow up, 4 of them with an uncertain outcome. This can be an indication that families terminate their involvement with the mental health professionals as soon as the children are attending school regularly and free from any physical symptoms (Finch and Burke 1960).

One factor that could have influenced the outcome positively was that the majority of the cases qualified as "acute" school refusing cases, (Berg et al 1969) reported to respond more favourably to treatment intervention. The mode of onset seemed to have had a stronger influence on treatment outcome than the ages of the children since the majority of them were older (9 - 13 years). Older children and adolescents are reported to be more resistant to therapeutic intervention than younger children. Older refusers also suffer more extensive disorder and their prognosis seems very much poorer (Atkinson et al 1985).

When comparing treatment method with successful outcome, the inclusion of family and school in the treatment process proved to be the most successful method of treatment. Counselling as the only method of treatment proved to be the least successful method of treatment. These findings support the general principle that all parties involved should be included in the treatment programme, planning the child's return to school as soon as possible (Lassers et al 1973 and Talbot 1957).

Evidence of previous episodes of school refusal was present in 2 of the 3 cases who failed to respond to a single method of treatment. These 2 cases also represented 7 member families from the low socio-economic group. It can be postulated that a repetition of school refusal reflects on the sustained presence of unresolved causative factors and/or the addition of other causative factor(s) to a child already sensitized to respond with school refusal. Similar cases would therefore demand a more elaborate treatment plan to deal more effectively with the different causative factors involved.

The varied responses to the different methods of treatment as recorded in this study support the description of school refusal as a syndrome (Hersov 1985). It is therefore also unlikely that one method of treatment will be appropriate for every case.

The most suitable approach will have to include a systematic assessment of each case as a unique clinical problem and a treatment programme that will include all parties concerned to effect early return to school.

CHAPTER 6

6. CONCLUSION AND RECOMMENDATIONS

6.1 CONCLUSION

This study was aimed at investigating the phenomenon School Refusal, as observed at the Child and Family Unit, Red Cross War Memorial Children's Hospital, Cape Town with particular reference to Clinical characteristics, Treatment and Outcome.

School refusal as described in this study was defined by

- severe reluctance to attend school;
- severe emotional upset when faced with the prospect of going to school; and
- absence of antisocial disorders.

School refusal was also found to be a "symptom" occurring in conjunction with diagnostic entities such as affective disorder, anxiety disorder, conversion disorder and gender identity disorder of childhood.

Recurrence of school refusal was evident in more than a third of the cases. The majority of cases were thus refusing school for the first time.

Clinical characteristics investigated included age at onset, gender, significant associated events, other presenting problems apart from school refusal, family size and family functioning, scholastic achievements, psychiatric disturbance in family members, duration of school refusal, previous episodes of school refusal and diagnostic categories.

Most of the cases investigated were in the 9 - 13 year age group with almost equal representation of boys and girls. Black children were not represented in this study.

Family related factors likely to influence the onset of school refusal were also reported. The majority of associated events were family bound and almost all the families were dysfunctional. A significant number of the families also tended to be

large, from low socio-economic status, and both parents presented with a recognizable psychiatric disorder in just over a third of the cases.

Presenting problems other than school refusal were represented by both affective and anxiety symptoms in about three quarters of the cases. It may however, be difficult to distinguish between symptoms of depression and symptoms of severe anxiety. Physical symptoms were also frequently recorded in conjunction with depressive and anxiety symptoms as well as part of a conversion disorder in one instance.

Slightly less than a third of the children suffered educational difficulties in that they failed one or two years at school - a characteristic of school refusal previously supposed to be uncommon.

The majority of the cases qualified as "acute" school refusers, usually indicating a better prognosis and a more favourable response to treatment. Successful return to school in this study was effected in almost two thirds of the cases. A success rate in close proximity to the generally accepted success rate of two thirds or more.

Treatment plans included single methods of treatment or combinations of different treatment methods.

The most effective form of treatment recorded was when both the family and the school personnel were included in the treatment plan. A single method of treatment was unsuccessful, especially when applied to cases presenting with recurrence of school refusal.

6.2 RECOMMENDATIONS

Introduction

With a greater awareness of school refusal, and the study completed, the following recommendations are suggested.

Most sources of referral demonstrated a limited understanding of the multifaceted nature of school refusal. School teachers in particular, who are in regular contact with the child, need to be aware of the key role played by physical symptoms in masking the presence of underlying school refusal. Teachers can also play an

important part in reporting cases of school non-attendance soon after onset. Prompt referral by the teacher reduces the time lapse between symptom onset and beginning of treatment on the one hand and promotes the likelihood of successful outcome on the other hand.

The same argument holds true for all other referring agents. The referring agents will only be able to assist effectively in the overall management of school refusal if they are properly informed.
An important function of the diagnostic evaluation is to include an assessment of the relative importance of causes in the family, the child and the school. In each case the causes have multiple bio-psychosocial components, necessitating a pluralistic approach to treatment. Assessment procedures practiced at the Child and Family Unit are effective in eliciting the various causative factors. Treatment plans on the other hand were not always recorded as pluralistic in approach. School personnel were included in less than half of the treatment plans. Future treatment plans should include the school personnel in all cases. Medication could possibly be used more often, especially to alleviate severe symptoms of anxiety in an effort to foster early return to school.

This advocated pluralistic approach should therefore include all the available treatment methods to meet the bio-psychosocial needs of each case individually.

6.3 FUTURE RESEARCH

This study highlighted some of the major restrictions of a retrospective study based on a relatively small sample size.

A different research approach can also be used to study the phenomenon of school refusal as represented in the South-African context. An experimental design to investigate causes and effects of non-delinquent school non-attendance may be more suitable to investigate prevailing conditions. Possible aspects for future research could include:

(a) the significance of ordinal positions;

(b) duration of treatment;

(c) the specific psychiatric disorders present in family members;

(d) the relevance of the educational system to the needs of the pupils, and the effect it has on school attendance.

(e) the role of the prevailing socio-political factors.

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APPENDIX 1

for office use

Case Number

SCHOOL REFUSAL

1. Sex

Male	1	Female	2

2. Age of Presentation

Yes ..... No .....

3. Number of standards failed ....

4. Race

Asian	1
Black	2
Coloured	3
White	4

5 Family Composition

Relationship	Age	Educ. Qual.	Occupation
....	.....	....	....
....	.....	....	....
....	.....	....	....

for office use

6. Marital Status of Parents

Married	1
Divorced	2
Single	3
Separated	4
Deceased	5
Cohabiting	6
Absent\living elsewhere	7
Not known	8

7. Presenting Complaints

7.1 Duration of present complaint (in months) ....

7.2 Previous School Refusal

yes	1	no	2

7.3 Significant associated events (eg death of family, separation, illnesses, moving home etc.) ....

....

8. Referred by:

Mother	1
Father	2
School	3
School Psychological Services	4
Doctor	5
Welfare agency	6
Primary health care services	7
Psychologist(private)	8

for office use

9. IQ assessment

yes	1	no	2

Total IQ score ....

10 Family Function (McMaster)

Problem solving	1
Roles	2
Communication	3
Affective involvement	4
Affective responsiveness	5
Behaviour control	6

11 Indication of Presence of Psychiatric Disorders:

11.1 Father Y/N ....

11.2 Mother Y/N ....

11.1 Siblings Y/N ....

12 Child's diagnosis: Axis I: ....

....

13 Other presenting problems e.g. stealing, lying, etc. (specify)....................

....

for office use

14 Treatment

Individual treatment	1
Family therapy	2
Behaviour therapy	3
Drug treatment	4
Hospitalisation	5
Environmental manipulation	6
Counselling	7
Liaison with school	8
Remedial teaching	9
Assessment only	10
Marital therapy	11

15 Outcome

Resolution	1
Recurrence	2
No improvement	3
Lost to follow up	4
Referred to welfare organisation	5
Referred to school psychological services	6
Referred back to psychologist (private)	7

APPENDIX 2

Other presenting problems refers to problems/symptoms other than refusal to attend school, entered into the clinical files under the heading "presenting problems". The problems/symptoms were categorized into 5 major categories corresponding to the most likely clinical psychiatric diagnosis. The categories are:

1. Anxiety symptoms,
2. Affective (depressive) symptoms,
3. Symptoms indicative of a somatoform disorder.
4. Symptoms referring to oppositional defiant behaviour.
5. Symptoms diagnostic of a gender disorder of childhood.

APPENDIX 3

"Associated events" is the term used to describe significant events, as gleaned from the literature, that could have influenced the onset of school refusal.

These events were arranged into 4 main group. Each group represented an aspect reported to influence the child's coping abilities to a greater or lesser extent.

The groups are:

1. Events related to the school situation - teacher-pupil conflict, high teacher turn over-rate, change of school, etc.

2. Events referring to family functioning, and intra/inter-familial relationships. Events included in this group were parent-child conflict, death in the family, psychiatric illness in a close relative, birth of a sibling, etc.

3. Events occurring in the child's immediate social environment like change of neighbourhood, loss of friends, etc.

4. Factors involving the child more personally such as a physical illness other than physical symptoms due to anxiety or depression.

APPENDIX 4

The families were reported to be dysfunctional families when they failed in 3 or more areas of family functioning as explained by the McMaster Model of Family Functioning (Epstein & Bishop, 1981).

APPENDIX 5

5.1 Age of parent:

The parents were grouped into the following 3 age groups:

1. 20 - 29 years.
2. 30 - 39 years.
3. 40 - 49 years.

5.2 Qualification of parent:

The highest level of qualification obtained by the parent was recorded by a number. These numbers were in accordance with the highest level of academic attainment be it at primary- or secondary school level or at a tertiary level. The numbers up to number 5 were indicative of a primary school education only. From number 6 to 10 corresponded with a secondary school education, whereas the figure 11 was indicative of a tertiary education.

5.3 Occupation of parent:

Parental occupation was divided into 6 categories:

1. Professional.
2. Semi-professional.
3. Administrative.
4. Technical.
5. Unskilled/Semi-skilled.
6. Unemployed.

These categories, were constructed arranging the parental occupations as recorded in the clinical files into the various categories.

Occupations reminiscent of the different categories were as follows:

1. **Professional:**
   Executive of a company.

2. **Semi-professional:**
   Managerial position in a company.

3. **Administrative:**
   Clerk, shorthand typist, receptionist, etc.

4. **Technical:**
   Motor mechanic, maintenance in a factory.

5. **Unskilled/Semi-skilled:**
   Cleaner, hawker, machine operator, house aid.

6. **Unemployed:**
   Disability grant, unemployed.

The highest level of education was also considered when constructing these categories, especially when the "housewife" was grouped.

APPENDIX 6

Diagnoses were made in accordance with DSM III R diagnostic criteria. Because of the retrospective nature of the study, and data being taken from clinical files, some criteria were not easily verifiable. Because of this, diagnoses of affective or anxiety disorders could not always be sub-classified. To distinguish between a major affective disorder (depression) and dysthymic disorder was not possible nor was the distinction between separation anxiety disorder, overanxious disorder and avoidant disorder of childhood always possible. The diagnostic categories used are:

- Anxiety disorder.
- Affective disorder (depression).
- Gender identity disorder.
- Somatoform disorder (conversion disorder).