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Practitioner Review: School refusal: developments in conceptualisation and treatment since 2000

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Background: A generation has passed since the literature on the conceptualisation, assessment and treatment of school refusal was reviewed in this journal (Elliott, 1999). In the light of considerable gaps in the literature, identified at that time, and growing international interest, the current paper sought to identify progress subsequently made this century. **Methods:** We open with discussion of continuing conceptual uncertainty as to whether school refusal should incorporate both truancy and absenteeism marked by anxiety and distress. We then consider progress in treatment, and conclude by examining prognosis and subsequent adult functioning. In selecting intervention studies for review, our primary focus has been upon RCTS, systematic reviews and meta-analyses. **Results:** The literature review indicates that, since the turn of the century, there has been little substantial advance in knowledge that can guide practitioners. Many of the issues raised in the 1999 paper, in particular, conceptual confusion over this heterogeneous condition, a dearth of rigorous RCT designs, limited knowledge of underlying mechanisms and uncertainty as to the long-term effects of specific forms of intervention, are little clearer than before. **Conclusions:** While several sound publications are available to guide intervention for school refusal, there is a continuing need for rigorous studies that can provide evidence to support individualised and tailored responses to an incapacitating problem with many causes and manifestations. While a multisystemic response to intervention approach is considered attractive, the practicalities of operating this across disparate professional borders are likely to present a long-term challenge. **Keywords:** Anxiety; cognitive behaviour therapy; fears; phobias; school attendance; school refusal.

Introduction

When a child has difficulty in attending school the reasons which lay behind this presentation can be numerous. Some 18 years ago, the current state of knowledge about such difficulties was reviewed in this journal (Elliott, 1999). Since then, interest in this topic has burgeoned, with increasing numbers of studies taking place in non-English-speaking countries such as Spain (Inglés, Gonzálvez, García-Fernández, Vicent, & Martínez-Monteagudo, 2015), Chile (Gonzálvez et al., 2017), India (Nair et al., 2013), Sri Lanka (Fernando & Perera, 2012), Japan (Maeda, Hatada, Sonoda, & Takayama, 2012) and South Korea (Park et al., 2015). A generation later, and with this broader international perspective, it seems timely to consider what progress has been made over the intervening period. Thus, this review as far as is practicable, focuses upon developments in the present century, with particular emphasis upon treatment. In so doing, it seeks to avoid reiterating the contents of the earlier paper (in particular, detailed description of assessment methods and discussion of different behavioural approaches).

Conceptualisation

At the turn of the present century, a number of researchers and clinicians were arguing that all child-motivated problems in school attendance, no matter what their origin, should be termed school refusal (Kearney, 1995). While this position has its adherents (e.g. Suveg, Aschenbrand, & Kendall, 2005), Kearney, has since suggested the use of the term 'school refusal behaviour' as the preferred construct. This term provides no suggestions of causality but, rather can be understood by the functions that are served by nonattendance. While attractive to many, others prefer to maintain a classificatory distinction between school refusal and truancy (Havik, Bru, & Ertesvåg, 2015; Steinhausen, Müller, & Winkler, 2008).

Elliott's (1999) review discussed the historical distinction between the school refuser and the truant at some length, and this material will not be repeated here. However, it is important to note that there continues to be debate as to the extent to which nonattenders fit into clear-cut groups (Egger, Costello, & Angold, 2003; Heyne, Sauter, & Maynard, 2015). Nevertheless, as in the earlier analysis (Elliott, 1999), this review does not directly address the treatment of truancy-based forms of school absenteeism. Rather, the term 'school refusal' is employed to refer to those for whom absenteeism is associated primarily with emotional difficulties, particularly anxiety. Depression has a less specific association, and while a common feature of school refusal, it also tends to show increased prevalence in truants (Havik et al., 2015).

Given the differing conceptualisations utilised, it is difficult to be clear about epidemiology, Egger et al.

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(2003) estimated that approximately 1%–2% of the general population engage in school refusal although this is at the lower end of many estimates. In a large sample of 5,465, 11–15-year olds, employing a self-report measure, Havik et al. (2015) found that about one child in each class (approximately 4%) reported being absent for issues typical of school refusal. They suggest that, because of the significant nonresponse rate, this figure may represent an underestimate. Steinhausen et al. (2008) obtained self-reports from 834 Swiss children aged between six and seventeen at two-time points. The researchers found that, at the first-time point (student mean age = 13 years), 104 children reported some form of school absenteeism. Of these, 57 (6.9% of the total sample) reported a fear of school (with a further six children reporting both fear of school and characteristics of truancy). Three years later (Time 2), the frequency of those reporting fear of school had dropped to 3.6%. In contrast, rates of truancy for the sample had increased (from 5% to 18.4%). The authors noted that the proportion reporting fear of school was not significantly different to other estimates of school refusers that have ranged between 1% and 5%.

A complicating feature of the school refusal/truancy distinction is that some forms of nonattendance tend to be viewed more sympathetically than others, and this is likely to affect adult responses (Torrens Armstrong, McCormack Brown, Brindley, Coreil, & McDermott, 2011). Lyon and Cotler (2007) argue that because of the legal nature of the term, and its association with conduct disorder, those considered to be engaging in truancy may be more likely to be seen as culpable. The impact of labelling can result in differential access to professional services, and forms of intervention, with truancy often more likely to result in legal proceedings that may reflect a punitive, rather than a therapeutic, focus (Lyon & Cotler, 2007). However, it should be noted that any suggestion that nonattenders from disadvantaged socially backgrounds are more likely to be perceived as truants, and subsequently subjected to less sympathetic forms of intervention, needs to be treated with caution until tested by well-designed empirical studies.

School refusal is a diagnostic term not used in the classification systems of the Diagnostic and Statistical Manual of Mental Disorders, 4th edition (DSM-IV) (American Psychiatric Association, 1994) or the World Health Organisation's International Classification of Diseases 10th edition (ICD-10) (World Health Organisation, 1992). This continues to be the case with DSM-V (American Psychiatric Association, 2013) although a high proportion of school refusers, as understood in the present paper, will most likely meet DSM-V criteria for a specific phobia, a generalised or social anxiety disorder, or separation anxiety, with a significant proportion also demonstrating depressive symptoms (Bernstein, 1991; Walter et al., 2013).

A helpful operationalisation of school refusal, drawing upon Berg's earlier criteria (Berg, 2002; Berg, Nichols, & Pritchard, 1969) has been offered by Heyne and his colleagues (Heyne, Sauter, van Widenfelt, Vermeiren, & Westenberg, 2011; Maric, Heyne, Mackinnon, van Widenfelt, & Westenberg, 2013). The selection criteria they have employed are as follows:

1 Less than an 80% attendance record over the past 2 weeks (excluding legitimate absences);
2 The presence of an anxiety disorder as identified in DSM-IV (APA, 1994) [excluding obsessive-compulsive disorder and post-traumatic stress disorder (PTSD)];
3 Parents could account for the whereabouts of the child on the days marked by school absence;
4 No concurrent DSM-IV conduct disorder (although mild forms of oppositional defiance are permitted);
5 Clear commitment on the part of parents to help the child to achieve full school attendance except when for legitimate reasons.

There is evidence that anxiety disorders in general, and separation anxiety specifically, are linked to dysregulation in the fear and stress response system in the brain, and are probably one of the most common mechanisms prompting school refusal (Bagnell, 2011). However, if the attendance difficulties have their roots in issues such as bullying then it is possible that the presentation is actually one of post-traumatic stress disorder (PTSD). One study, for example, found that of bullied students, 27.6% of the boys and 40.5% of the girls had scores within the clinical range for PTSD (Idsoe, Dyregrov, & Idsoe, 2012).

Separation anxiety is considered to be a relatively common disorder (American Psychiatric Association, 2013) that is associated with panic attacks (Kossowsky et al., 2013) and is often a precursor to school refusal. About three quarters of children who present with separation anxiety disorder have at least one episode of school refusal (Hella & Bernstein, 2012). However, the original belief that separation anxiety could explain almost all cases of school refusal has now been largely discredited. This explanation underplays the role of powerful school-based factors and fails to explain why the peak age for school refusal is between the ages of 11 and 13 (Last, Francis, Hersen, Kazdin, & Strauss, 1987) rather than in the early years of schooling as the theory would suggest. Furthermore, many refusers appear to experience no significant difficulty in separating from the caregiver to associate with peers in nonschool settings.

Clearly, there are many cases where adverse events in school are important factors in the refusal and are a key source of anxiety. (Steinhausen et al., 2008). However, the use of terminology differs somewhat. Thus, Burke and Silverman (1987) differentiate between separation anxiety and school

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phobia, a term they use to describe a fear of school. In contrast, Knollman, Knoll, Reissner, Metzelaars, and Hebebrand (2010) differentiate between school anxiety (where fearfulness is associated with the school environment) and school phobia (which they see as being a consequence of separation anxiety). However, given that school environments are very social settings, some presentations may be more accurately described as reflecting social anxiety, involving intense distress in response to public situations (Beidel, 1998). In some cases, students may show fear of both specific features of the school environment and also its more general social and evaluative aspects (Haight, Kearney, Hendron, & Schafer, 2011).

Assessment

In undertaking an initial assessment, Elliott and Place (2012) point out that it is important to recognise that the school refusal could be a secondary symptom of another pervasive problem. The somatic symptoms associated with anxiety, such as palpitations or abdominal pain could have a physical origin and, therefore, medical assessment involving a physical examination with appropriate follow-up is likely to be valuable. Conversely, it is possible that caregivers and school staff may mistakenly consider stress-related somatic problems to be purely physical ailments and this may, in some cases, result in delays in appropriate treatment with deleterious consequences (Havik et al., 2015).

Educational and psychological assessments typically examine the level of the child's academic ability because low functioning is a prominent complaint in school refusers (Fernando & Perera, 2012). Intellectual assessment, particularly verbal ability, will help to indicate what role cognitive therapy might play in intervention. Broader mental health assessment to understand the issues and identify comorbidities is key to ensuring that intervention is most effective for that individual. This typically involves interviews with the child, the parents, and the family, in order to provide the fullest picture of functioning. Detailed examination of the child's perspective is necessary. For example, there is some evidence that school refusers are more likely to have pessimistic thoughts about personal failure (Place, Hulsmeier, Davis, & Taylor, 2000, 2002), that can undermine the their sense of self-efficacy with respect to returning to regular attendance (Maric et al., 2013).

Elliott (1999) listed a number of assessment tools that were often used to guide structured interview or used for the purposes of self-report of anxiety or depression. Such measures are not geared specifically to examine school refusal although a more recent tool, *the Child Anxiety Life Interference Scale* (Lyneham et al., 2013) seeks to examine the effect of anxiety upon daily life, including several aspects of school experience. Lyneham et al. (2013) report sound psychometric properties for the scale and conclude that this measure can be used effectively to complement more general measures of childhood anxiety. Lyneham, Street, Abbott, and Rapee (2008) have produced a teacher report scale addressing the child's observed behaviour in school. While these authors report some promising preliminary supportive evidence, it does not appear that any further validation work has been published.

Absence from school can provide both negative reinforcement (by removing the child from stressful situations), and positive reinforcement (by providing attractive alternative activities and desired attention). Assessment should seek to ascertain the extent to which a child's unwillingness to attend school is a response to particular elements of the school context itself, a general fear of potentially stressful social situations, a reluctance to leave the family home and perhaps gain additional parental (and other) attention, and a perception that alternative settings are more rewarding than school.

The School Refusal Assessment Scale (Kearney & Silverman, 1993), discussed by Elliott (1999), offers a means to assess key functions of illegitimate nonattendance: (a) avoidance of negative effect, often resulting from specific fears, (b) escape from social aversion or evaluation situations, (c) seeking attention, often stemming from separation anxiety, or (d) seeking tangible reinforcements outside of school). Revised and enlarged in 2002 (Kearney, 2002), in part to improve its psychometric properties, the measure includes both child and parent versions that enable the assessor to develop hypotheses about factors underpinning the refusal. Derived understandings, it is argued, can provide a helpful guide for intervention. The Scale is widely reported in the school refusal literature and has been translated into various languages, for example, German (Walter, von Bialy, von Wirth, & Doepner, 2017), Spanish (Gonzálvez et al., 2016) and Turkish (Seçer, 2014).

Heyne, Vreeke, Maric, Boelens, and van Widenfelt (2016) reported some psychometric challenges that followed from the Scale's revision. They offer an adapted item set that, while closely mirroring the existing items, is deemed to offer less ambiguity and complexity. Employing their revised measure with school refusers and their parents, these authors found support for Kearney's four-factor model, improved internal consistency and some evidence of concurrent validity.

Of course, the child's refusal to attend school may often have overlapping functions. In order to provide a detailed and nuanced understanding, the use of the Scale should be complemented by interview and observational data, and parent, teacher and child self-report measures. Also, the measure may be less valuable when considering severe or chronic cases where many contextual influences may operate (Kearney, 2016). While Kearney's conception seemingly has merit, the

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extent to which a functional analysis of this kind actually serves to improve clinical outcomes is an issue that requires further empirical investigation (Heyne et al., 2016).

A significant development this century has been increased awareness of the role that school environments play in the development of school refusal (Knollman et al., 2010). Understanding that a student may be refusing school in order to avoid an aversive experience necessitates identification of particular school-based factors that are contributing to the problem (Havik et al., 2015). Clearly, academic pressures, often exacerbated by high stakes testing, can lead to unbearably high levels of anxiety (Connor, 2001, 2003; Denscombe, 2000; Putwain, 2007). Negative peer experiences can also be influential and this century has seen greater recognition of the pervasive trauma associated with bullying. Many students have had to contend with a rise in 'bias bullying' which results from the victim's perceived membership of a particular, often marginalised, group (e.g. based upon gender, race/ethnicity, sexual orientation, faith/religion and disability) rather than as a result of their individual characteristics (Walton, 2017). Cyberbullying is a relatively new form of bullying involving the use of everyday electronic devices and social media platforms. While often experienced outside of school, this frequently appears to originate from those known at school (Smith et al., 2008). Thus, hostile messages received in the relative safety of the child's home may greatly increase the perceived comparative threat of the more distal school context (Katzer, Fetchenhauer, & Belschak, 2009).

The understandings that school personnel have about the reasons for a student's school refusal are also likely to affect the manner in which they respond. Torrens Armstrong et al. (2011) outline a range of themes that are used by school staff to describe different kinds of refuser. These place upon the student varying degrees of blame, victim status and legitimacy. Although it is currently unclear how such understandings impact upon future refusal behaviour, it would seem likely that the school will be more accommodating of any need for special arrangements if the student is perceived as a victim of factors beyond their control. Thus, assessment should not only identify the reasons behind should refusal but also consider how understandings of these may impact upon the willingness of school staff to be maximally supportive to the child.

Treatment

The overarching aim of intervention is the reduction of the young person's emotional distress and an increase in school attendance, outcomes that will help them follow a normal developmental pathway. Intervention programmes for school refusal appear to be more successful for younger children, irrespective of the approach employed (Prabhuswamy, Srinath, Girimaji, & Seshadri, 2007; Valles & Oddy, 1984), although differences in age for adolescent refusers appear not to be a predictor (Layne, Bernstein, Egan, & Kushner, 2003; Walter et al., 2013). There are several factors that may contribute to the greater difficulty encountered in intervening with older children. Adolescent refusers tend to have a greater sense of autonomy than younger children that can help them to refuse adult strictures. They may encounter greater difficulty in re-engaging with more complex, demanding, specialised curricula at a stage when high stakes testing is becoming more pressing. Finally, at this stage in their school lives, adolescents often tend to experience more severe symptoms (Hella & Bernstein, 2012; Heyne, Sauter, Ollendick, van Widenfelt, & Westenberg, 2014).

A wide range of treatments can be deployed depending upon individual need. The most popular approach continues to be cognitive behaviour therapy, often incorporating exposure-based behavioural programmes, although the use of family work and pharmacotherapy is also recommended where appropriate. Many treatment approaches incorporate a focus upon contextual factors in both the home and in school that may increase or alleviate anxiety (see Elliott, 1999, p. 1007–1008, for an outline of important issues that school personnel should consider tackling school refusal).

Cognitive Behaviour Therapy

Elliott (1999) noted that Cognitive Behaviour Therapy (CBT) had largely replaced psychoanalytic approaches as the preferred method of treatment for school refusal. In a series of more recent reviews, this approach has also been found to be effective in alleviating a range of anxiety disorders for young people (e.g. Higa-McMillan, Francis, Rith-Najarian, & Chorpita, 2016). In the opinion of some, it, '... is the only intervention for school refusal behaviour with sufficient empirical support to be considered a first-line treatment' (Doobay, 2008, p.265). While the components of the approach may vary according to professional interests and expertise, it typically draws upon a combination of psychoeducation, relaxation training, social skills training, gradual exposure and cognitive restructuring (Melvin & Tonge, 2012).

Standard CBT manuals developed for the treatment of anxiety or depressive disorders may not be appropriate for tackling school refusal, given its highly heterogeneous nature (Heyne & Sauter, 2013), and this may explain the high dropout following their use (Beidas, Crawley, & Mychailyszyn, 2010). Maynard, Heyne et al. (2015) describe the contents of five CBT manuals for treating school refusal (Heyne & Rollings, 2002; Heyne, Sauter, &

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Van Hout, 2008; Kearney & Albano, 2000; Last, 1993; Tolin et al., 2009). All but one (Last, 1993) utilise a form of individualised treatment based upon the functions served by the nonattendance together with consideration of 'predisposing, precipitating, perpetuating, and protective factors' (Maynard, Heyne et al., 2015 p. 3).

Reissner, Hebebrand, and Knollmann (2015) have developed a manual-based, multiprofessional multimodal treatment approach comprising four modules. The 'most important' (p. 656) of these involves the provision of cognitive behaviour therapy that has been specifically adapted from pre-existing manuals to specifically address school avoidance. The remaining three modules focus upon family counselling, school-related counselling and the provision of strategies to assist the child to function more effectively in social and other settings.

Reissner, Jost et al. (2015) employed an RCT design to compare the effectiveness of this approach with treatment as usual provided by a mental health practitioner. It was found that both approaches were equally effective in increasing school attendance 6 and 12 months later. However, because of the need to intervene swiftly with such cases, there were no waiting list controls, rendering judgement as to treatment effectiveness difficult to determine. Walter et al. (2010) examined the effects of inpatient therapy with anxious-depressed adolescents with chronic school absenteeism. Their intervention employed manualised CBT therapy supplemented by family work, inpatient support involving graduated exposure and training in the productive use of leisure time. Significant gains were found in school attendance with reduced comorbid mental health problems. However, the absence of a control group did not permit conclusions to be drawn about the role of the treatment itself.

Highlighting the need for individualised forms of treatment within a modularised programme, Heyne et al. (2014) advocated the use of a developmentally sensitive approach that tailors the treatment to the particular developmental level and family circumstances of the young person. While the role of parents is typically viewed as less crucial in the treatment of general anxiety or depression (Breinholst, Esbjorn, Reinholdt-Dunne, & Stallard, 2012; Clarke, Rohde, Lewinsohn, Hops, & Seeley, 1999), greater emphasis upon parental involvement would appear to be important for work with school refusers (Heyne et al., 2014).

Despite this, support from controlled trials for the value of parental involvement as part of CBT programmes is modest. The only randomised trial considering the additional benefit of parental involvement in a CBT intervention for school refusal (Heyne et al., 2002) reported no additional benefits in reducing emotional distress. However, there were some improvements in subsequent school attendance. Another randomised controlled study involving children with separation anxiety disorder (Schneider et al., 2013) concluded that the inclusion of parent training failed to add large effects to classical child-based CBT. Despite these findings, parents are likely to play an important role in a comprehensive treatment programme (Heyne et al., 2014), particularly, perhaps, where parental anxiety is high (Creswell & Cartwright-Hatton, 2007). Helpful guidance for undertaking such work is provided by Swan, Kagan, Frank, Crawford, and Kendall (2016).

A recent systematic review and meta-analysis (Maynard, Brendel et al., 2015; Maynard, Heyne et al. (2015)) identified six RCTs involving psychosocial interventions for school refusal (with five studies utilising CBT). Two further studies reviewed incorporated a quasi-experimental design. The reviewers noted that risks of bias which could have increased effect sizes were present in most of the studies. Nevertheless, they concluded that the results provided 'tentative support for CBT for the treatment of children and adolescents with school refusal' (Maynard, Heyne et al. 2015, p. 6). Interestingly, findings from this study showed that gains made in respect of attendance were not mirrored by decreases in anxiety levels. Of course, achieving reintegration to school is likely to raise the child's anxiety, whereas remaining at home may often result in lower levels of distress. Researchers, therefore, need to be explicit about whether the primary outcome sought in their intervention studies is reduction in anxiety or increased school attendance. A review by Pina, Zerr, Gonzales, and Ortiz (2009) covers similar ground, concluding that the evidence for using a combination of behavioural and cognitive approaches for reducing school refusal 'seems promising' (p. 5).

In Elliott's (1999) review of treatment for school refusal, it was stated that:

> Until large-scale controlled evaluations are conducted it will remain unclear whether specific elements of CBT are key in treating school refusal and the extent to which these are mediated by particular sociodemographic or clinical characteristics (p. 1006).

A generation later, these issues are still unresolved. Indeed, with reference to the treatment of child and adolescent anxiety more broadly, Higa-McMillan et al. (2016) argue that future efficacy trials need to search for specific features that can increase or enhance what we understand to be the positive effects of CBT. These authors point out that we are still ignorant as what are the key ingredients of CBT, and what is the best sequence for combining elements of the programme, or how and why treatments work. For example, it is unclear under which circumstances exposure should precede, or follow, skills training. As is the case for youth anxiety and depression more generally, it may be helpful to identify social and cognitive mediating

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factors in school refusal that can have an important influence upon outcomes (Heyne et al., 2015). For example, Maric et al. (2013) provide some support for the argument that self-efficacy may be an important mediator that could be directly targeted by both prevention and intervention programmes.

Behavioural approaches

Behavioural approaches for school refusers are primarily exposure-based and draw upon such techniques as systematic desensitisation (incorporating relaxation training), flooding, emotive imagery, modelling, shaping and contingency management (Elliott & Place, 2012). The use of behavioural exposure as a powerful component of CBT programmes for anxiety reduction in children has empirical support (Higa-McMillan et al., 2016; Voort, Svecova, Jacobsen, & Whiteside, 2010) although this is unattractive to some therapists., Peterman, Read, Wei, & Kendall, 2015) contend that therapist resistance to exposure is often based on various myths, and cite studies that challenge each of these: fears that exposure may be dangerous and lead to litigation (Richard & Gloster, 2007), may increase dropout (Gryczkowski et al., 2013), can undermine the therapeutic alliance (Kendall et al., 2009), can be seen as unhelpful by clients (Kendall & Southam-Gerow, 1996), and may be perceived by the client as rigid and unpleasant (Kendall & Beidas, 2007). While graduated forms of exposure are routinely employed in coaxing the young person back into school, Elliott (1999) highlighted controversy in the use of enforced return (a form of flooding) (see also, Kearney & Albano, 2007). Such practices may be seen as potentially vulnerable to litigation, particularly as evidence of its efficacy and appropriateness has been largely absent in the research literature.

Having argued a strong case for the use of behavioural exposure as a powerful component of a skills-based approach (see also Whiteside, Deacon, Benito, & Stewart, 2016), Peterman et al. (2015) provide helpful practical guidance for operating exposure techniques, including in work with those whose school refusal represents an attempt to avoid anxiety-provoking situations. A major challenge is that, for exposure to prove effective, there needs to be close, ongoing collaboration with school staff who may sometimes find the extensive time requirements of organising and monitoring individualised school return programmes rather burdensome (Maeda et al., 2012).

Family therapy

The influence of the family is a key factor to consider in developing a treatment plan and, as Berg (1992) observed, it is only when the child realises that parents are determined to effect their return to school that real progress tends to be made. Clearly, involving the family in the intervention, alongside school staff, is likely to be essential in most cases (Doobay, 2008). While family therapy has long been advocated for the treatment of school refusal (Bryce & Baird, 1986; Lask, 1996; Richardson, 2016), there continues to be insufficient evidence that such an approach, in isolation, is as effective as individually focused therapies for the treatment of school refusal. Instead, family work is now often seen as more appropriately embedded within a CBT programme (e.g. Heyne et al., 2014; Walter et al., 2010; Reissner, Hebebrand et al., 2015.

Pharmacotherapy

Pharmacological treatments for school refusal continue to be contentious and the early arguments for (King, Ollendick, & Tonge, 1995) and against (Murphy & Wolkind, 1996) have continued. Reconciling this debate is problematic as few studies have reported on the value of medication for this problem. However, examination of the effects of medication in treating children with a range of anxiety disorders has found that anxiolytic medication gives a significantly greater clinical response than a placebo drug (Ipser, Stein, Hawkridge, & Hoppe, 2009). Selective serotonin reuptake inhibitors (SSRIs) are regarded as the pharmacological treatment of choice for anxiety disorders in children and adolescents because of their effectiveness and safety profile. However, other agents such as tricyclic antidepressants, anxiolytics, alpha-adrenergic agonists and beta-adrenergic blocking agents have also been used.

Studies have reported mixed results as to whether a combination of medication with CBT offers any additional clinical benefits for school refusal. Bernstein et al. (2000) investigated the effects of antidepressant medication (imipramine) with CBT, as compared with CBT and a placebo, for 63 school refusing adolescents experiencing anxiety and depression. It was found that a significantly greater proportion of the medicated children achieved the target 75% attendance rate by the end of the treatment. However, given the health risks of this type of medication, and its limited impact in reducing adolescent depression (Hazell & Mirzaie, 2013), its use is not recommended (Melvin et al., 2017). Melvin et al. (2017) employed an RCT design to examine whether augmenting CBT with fluoxetine improved school attendance and mental health for adolescents refusing school. Participants were selected on the basis of: <50% attendance for the past 4 weeks, evidence of severe emotional upset, an absence of characteristics of conduct disorder and parent evidence that parents had made reasonable attempts to enforce attendance. Each group receiving the interventions showed improved attendance and mental health (anxiety, depression, self-efficacy and clinician-rated

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global functioning), with gains maintained largely maintained 6 and 12 months later. Despite this, for each group, attendance remained at a level that was inadequate for effective schooling and there was no evidence that augmenting CBT with fluoxetine improved attendance or psychological functioning. In an RCT study of school refusers in China, Wu et al. (2013) found no additional efficacy for fluoxetine and CBT, in comparison with CBT alone, although improved school attendance was found for both groups.

An alternative model of service delivery

Kearney and Graczyk (2014) have suggested that the treatment of all forms of problematic absenteeism could operate effectively within a Response to Intervention (RTI) framework. Popular in the field of special education, RTI operates as a system-wide, structured problem-solving approach that ranges through various tiers of provision and practice. Crucially, following detailed assessment of progress, decisions about future action are primarily a consequence of how the child has responded to earlier intervention. Insufficient progress typically leads to more structured, more intense, more specialised, more individualised forms of intervention. RTI does not specify which forms of intervention should be utilised, only that this should have a strong supportive evidence base.

Kearney argues that an RTI approach may be particularly valuable for problematic school absenteeism because its key components involve: early identification, functional assessment of problem behaviours and monitoring of progress following intervention. It also advocates the adoption of interventions that have empirical support, are compatible with other multitier approaches, and have a focus upon teamwork.

The RTI approach, designed to effect a swift identification of, and intervention for, any child who is struggling within a specific domain, has much to commend it in relation to problematic areas of children's learning such as reading disability (Elliott & Grigorenko, 2014), mathematics difficulties (Fuchs, Fuchs, & Malone, 2016) or classroom misbehaviour (Grosche & Volpe, 2013). It is hardly surprising therefore that attempts to use this structure to address school absenteeism are now beginning to surface. However, it is our opinion, that a 'joined-up' approach of this kind, involving collaboration between a wide range of professional specialists, while theoretically persuasive, is currently impractical for the great majority of practitioners seeking to address the needs of those who struggle to attend school. In the case of reading disability, for example, an RTI approach can typically involve a range of professionals involved in education – classroom practitioners, specialist teachers, school (educational) psychologists and speech and language therapists. Here, professional roles and particular expertise relevant to the issue are widely known, there is a clear and logical instructional hierarchy, and movement through the tiers can operate relatively smoothly. For school absenteeism there is potential involvement from a much wider range of service providers (such as education, psychology, psychiatry, social work and juvenile justice) whose referral patterns, focus and approach may differ considerably. Thus, appropriate and timely movement through tiers, based upon the child's response to assistance from these various agents, will present a much greater challenge. Within RTI models, mainstream teachers typically have greatest responsibility for work at the early stages (Sullivan & Long, 2010), although concerns have been expressed about teacher understanding of the process and their training needs (Castro-Villareal, Rodriguez, & Moore, 2014). However, in contrast to dealing with learning or classroom behavioural difficulties, tackling absenteeism needs to involve speedy response from professionals located in sites other than the classroom who may also be unfamiliar with school-based practices.

While Kearney's comprehensive and multisystemic approach to the broader concept of school refusal behaviour is laudable, the difficulties noted above, which Kearney (2016) readily acknowledges, suggest that its operation is unlikely to be a realistic proposition in the foreseeable future for the vast majority of the readers of this review.

Prognosis and relationship with psychiatric disorder in adulthood

The many different understandings of school refusal render it difficult to speak with confidence about likely prognosis. It has been suggested that up to 25% of school refusal episodes remit spontaneously (Kearney & Tillotson, 1998), and in a small-scale study King et al. (1998) reported that 29% of their waiting list controls demonstrated a clinical improvement in attendance. However, there are likely to be important factors in the persistence of the problem after treatment such as its severity, the age of onset and the speed of response once a problem is identified (Knollman et al., 2010). Treatment is likely to be less effective in cases where the refusal has persisted for more than 2 years (Kearney & Tillotson, 1998) and there is some evidence that future employment, or education several years after treatment, is less likely where the child presents with social phobia or learning difficulties (McShane, Walter, & Rey, 2004).

As noted above, Melvin et al. (2017) found that after intervention some students improved significantly in their school attendance and emotional symptoms, but few were free of anxiety symptoms over the period of follow-up. Other studies (Flakierska, Linstrom, & Gillberg,1988,1997; Kearney,

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2001; McCune & Hynes, 2005) suggest that at least one-third of young people who have presented with school refusal (as the term is used in the present paper) are likely to experience serious adjustment difficulties in adulthood.

In relation to internalising conditions related to school refusal, the lifetime prevalence for anxiety disorders has been estimated to be 28.8%, with the median age of onset being 11 years of age (Kessler et al., 2005). Episodes of brief duration tend to prompt no further difficulty, and tend to reduce further as the person moves into adulthood (Patton et al., 2014), providing this transition is without upset (Copeland, Angold, Shanahan, & Costello, 2014). However, those with a thought disorder are three times more likely to carry this into adulthood (Costello, Mustillo, Erkanli, Keeler, & Angold, 2003; Patton et al., 2014). Kossowsky et al. (2013) meta-analysis of 25 studies (14,855 participants) showed that a childhood diagnosis of separation anxiety, a relatively common lifetime disorder (Silove et al., 2015), significantly increased the risk of anxiety disorders in adulthood. However, this diagnosis does not appear to predict major depression or substance use disorders later in life.

Concluding remarks: what have we learned this century about school refusal?

This review, written a generation after an earlier practitioner review in this journal (Elliott, 1999), leads to the conclusion that, while there have been many valuable studies in the field of school refusal in the intervening period, findings from these offer few additional and significant guidelines for practice that have the support of rigorous trials. This outcome may be partly explained by the heterogeneous nature of a problem that does not appear as a psychiatric disorder in APA and WHO classifications. While the earlier call for broader conceptualisations of school refusal (behaviour) has been taken up by some (e.g. Kearney, 2016), others prefer to maintain a clear distinction between school refusal and truancy (e.g. Maynard, McCrea, Pigott, & Kelly, 2012). Such uncertainty may undermine a continuing need for focused examination of effective treatments for anxiety-based nonattendance. Clearly, to achieve this, we need to agree upon clear school refusal criteria that can be consistently used for such studies (see, for example, those employed by Heyne et al., 2011; Reissner, Jost et al., 2015).

Cognitive behaviour therapy continues to be the therapy of choice (with a shift in emphasis from standardised to individualised approaches, and the incorporation of exposure techniques). The importance of supplementing this by working closely with family and school staff is now widely acknowledged. Studies undertaken this century suggest that CBT programmes of this kind can reduce absenteeism and mental health difficulties although, to date, researchers have been unable to show a clear causal link.

Case studies continue to dominate the research literature (Inglés et al., 2015) and the earlier call for randomised controlled studies to ascertain the efficacy of CBT, and to identify the key components within it, has yet to be answered. Questions such as to whether flooding (forced return) is an appropriate approach to employ in particular cases (Elliott, 1999), and the extent to which a return to school is necessarily helpful for later adult functioning, remain unanswered.

The difficulty of obtaining sufficient numbers of participants to conduct powerful RCTs for this complex heterogeneous condition may be a sustaining factor that needs to be overcome. This problem is exacerbated by ethical difficulties in the employment of waiting list controls. Certainly, controlled studies are needed to ascertain what treatments work, how they work, what are important mediating and moderating factors (although see Heyne et al., 2015, for a helpful account), whether, when and how medication can contribute, and how we can ensure the effective operation of evidence-based approaches in partnership with parents and teachers.

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Key Points

Key practitioner message

- A continuing divide exists between those who argue for and against a conceptual merger in which the term 'school refusal' or 'school refusal behaviour' includes both those anxious about attending school, and those who would historically be classed as truants;
- Some commentators have queried whether those labelled as truants are treated less sympathetically than those whose nonattendance is considered to be the consequence of high levels of anxiety;
- There has been little significant advance in the treatment of school refusal during the present century. Difficulties in achieving progress are likely to have been exacerbated by the heterogeneity of this problem;
- Evidence in support of particular forms of intervention remains scant. The value of individualised cognitive behaviour therapy, incorporating exposure, appears to have modest research support, although key mechanisms remain unclear.
- While it seems that family work is an essential aspect of treatment for school refusal, controlled studies examining family-based therapies have been rare and findings have proven equivocal;
- Repeated calls for well-designed randomised controlled trials examining the treatment of for school refusal have been largely ignored;
- There is little evidence to support the use of medication as part of a treatment programme for school refusal;
- Embedding intervention for school refusal within a multisystemic response to intervention approach is an attractive notion that is unlikely to be easily established across professional borders in the near future.

Areas for future research

- Controlled studies are needed to ascertain what treatments work, how they work and to identify important mediating and moderating factors.

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