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The authors reported no
potential conflict of interest
relevant to this article.

doi: 10.12788/jfp.0653

School avoidance: How to help when a child refuses to go

Many students want to skip school from time to time. But when absenteeism becomes chronic, it may indicate a more serious underlying issue.

▶ THE CASE

Juana*, a 10-year-old who identifies as a cisgender, Hispanic female, was referred to our integrated behavioral health program by her primary care physician. Her mother was concerned because Juana had been refusing to attend school due to complaints of gastrointestinal upset. This concern began when Juana was in first grade but had increased in severity over the past few months.

Upon further questioning, the patient reported that she initially did not want to attend school due to academic difficulties and bullying. However, since COVID-19, her fears of attending school had significantly worsened. Juana's mother's primary language was Spanish and she had limited English proficiency; she reported difficulty communicating with school personnel about Juana's poor attendance.

Juana had recently had a complete medical work-up for her gastrointestinal concerns, with negative results. Since the negative work-up, Juana's mother had told her daughter that she would be punished if she didn't go to school.

○ HOW WOULD YOU PROCEED WITH THIS PATIENT?

* The patient's name has been changed to protect her identity.

School avoidance, also referred to as *school refusal*, is a symptom of an emotional condition that manifests as a child refusing to go to school or having difficulty going to school or remaining in the classroom for the entire day. School avoidance is not a clinical diagnosis but often is related to an underlying disorder.¹

School avoidance is common, affecting 5% to 28% of youth sometime in their school career.² Available data are not specific to school avoidance but focus on chronic absenteeism (missing ≥ 15 days per school year). Rates of chronic absenteeism are high in elementary

and middle school (about 14% each) and tend to increase in high school (about 21%).³ Students with disabilities are 1.5 times more likely to be chronically absent than students without disabilities.³ Compared to White students, American Indian and Pacific Islander students are $> 50\%$ more likely, Black students 40% more likely, and Hispanic students 17% more likely to miss ≥ 3 weeks of school.³ Rates of chronic absenteeism are similar (about 16%) for males and females.³

Absenteeism can have immediate and long-term negative effects.⁴ School attendance issues are correlated to negative life outcomes,

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such as delinquency, teen pregnancy, substance use, and poor academic achievement.⁵ According to the US Department of Education, individuals who chronically miss school are less likely to achieve educational milestones (particularly in younger years) and may be more likely to drop out of school.³

WHAT SCHOOL AVOIDANCE IS (AND WHAT IT ISN'T)

It is important to distinguish school avoidance from truancy. Truancy often is associated with antisocial behavior such as lying and stealing, while school avoidance occurs in the absence of significant antisocial disorders.⁶ With truancy, the absence usually is hidden from the parent. In contrast, with school avoidance, the parents usually know where their child is; the child often spends the day secluded in their bedroom. Students who engage in truancy do not demonstrate excessive anxiety about attending school but may have decreased interest in schoolwork and academic performance.⁶ With school avoidance, the child exhibits severe emotional distress about attending school but is willing to complete schoolwork at home.

Why children may avoid school

School avoidance is a biopsychosocial condition with a multitude of underlying causes.⁴ It is associated most commonly with anxiety disorders and neurodevelopmental disorders, including but not limited to learning disabilities and attention-deficit/hyperactivity disorder.¹ Depressive disorders also have been associated with school avoidance.⁷ Social concerns related to changes with school personnel or classes, academic challenges, bullying, health emergencies, and family stressors also can result in symptoms of school avoidance.¹

A child seeking to avoid school may be motivated by potential negative and/or positive effects of doing so. Kearney and Silverman⁸ identified 4 primary functions of school refusal behaviors:

- avoiding stimuli at school that lend to negative affect (depression, anxiety)
- escaping the social interactions and/or situations for evaluation that occur at school

- gaining more attention from caregivers, and
- obtaining tangible rewards or benefits outside the school environment.

How school avoidance manifests

School avoidance has attributes of internalizing (depression, anxiety, somatic complaints) and externalizing (aggression, tantrums, running away, clinginess) behaviors. It can cause distress for the student, parents and caregivers, and school personnel.

The avoidance may manifest with behaviors such as crying, hiding, emotional outbursts, and refusing to move prior to the start of the school day. Additionally, the child may beg their parents not to make them go to school or, when at school, they may leave the classroom to go to a safe place such as the nurse's or counselor's office.

The avoidance may occur abruptly, such as after a break in the school schedule or a change of school. Or it may be the final result of the student's gradual inability to cope with the underlying issue.

HOW TO ASSESS FOR SCHOOL AVOIDANCE

Due to the multifactorial nature of this presenting concern, a comprehensive evaluation is recommended when school avoidance is reported.⁴ Often the child will present with physical symptoms, such as abdominal pain, nausea, vomiting, diarrhea, headaches, shortness of breath, dizziness, chest pain, and palpitations. A thorough medical examination should be performed to rule out a physiological cause. The medical visit should include clinical interviews with the patient and family members or guardians.

To identify school avoidance in pediatric and adolescent populations, medical history and physical examination—along with social history to better understand familial, social, and academic concerns—should be a regular part of the medical encounter. The School Refusal Assessment Scale-Revised (SRAS-R) for both parents and their children was developed to assess for school avoidance and can be utilized within the primary care setting. Additional psychiatric history for both the family and



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patient may be beneficial, due to associations between parental mental health concerns and school avoidance in their children.^{9,10}

Assessment for an underlying mental health condition, such as an anxiety or depressive disorder, should be completed when a patient presents with school avoidance.⁴ More than one-third of children with behavioral problems, such as school avoidance, have been diagnosed with anxiety.¹¹ The 2020 National Survey of Children's Health found that 7.8% of children and adolescents ages 3 to 17 years had a current anxiety disorder, leading the US Preventive Services Task Force to recommend screening for anxiety in children and adolescents ages 8 to 18 years.^{12,13} Furthermore, if academic achievement is of concern, then consideration of further assessment for neurodevelopmental disorders is warranted.¹

TREATMENT IS MULTIMODAL AND MULTIDISCIPLINARY

Treatment for school avoidance is often multimodal and may involve interdisciplinary, team-based care including the medical provider, school system (eg, Child Study Team), family, and mental health care provider.^{1,4}

Cognitive behavioral therapy (CBT) is the most-studied intervention for school avoidance, with behavioral, exposure-based interventions often central to therapeutic gains in treatment.^{1,14,15} The goals of treatment are to increase school attendance while decreasing emotional distress through various strategies, including exposure-based interventions, contingency management with parents and school staff, relaxation training, and/or social skills training.^{14,16} Collaborative involvement between the medical provider and the school system is key to successful treatment.

Medication may be considered alone or in combination with CBT when comorbid mental health conditions have been identified. Selective serotonin reuptake inhibitors (SSRIs)—including fluoxetine, sertraline, and escitalopram—are considered first-line treatment for anxiety in children and adolescents.¹⁷ Serotonin-norepinephrine reuptake inhibitors (SNRIs), such as duloxetine and venlafaxine, also have been shown to be effective.

Duloxetine is the only medication approved by the US Food and Drug Administration (FDA) for treatment of generalized anxiety disorder in children ages 7 years and older.¹⁷

SSRIs and SNRIs have a boxed warning from the FDA for increased suicidal thoughts and behaviors in children and adolescents. Although this risk is rare, it should be discussed with the patient and parent/guardian in order to obtain informed consent prior to treatment initiation.

Medication should be started at the lowest possible dose and increased gradually. Patients should remain on the medication for 6 to 12 months after symptom resolution and should be tapered during a nonstressful time, such as the summer break.

THE CASE

Based on the concerns of continued school refusal after negative gastrointestinal work-up, Juana's physician screened her for anxiety and conducted a clinical interview to better understand any psychosocial concerns. Juana's score of 10 on the General Anxiety Disorder-7 scale indicated moderate anxiety. She reported symptoms consistent with social anxiety disorder contributing to school avoidance.

The physician consulted with the clinic's behavioral health consultant (BHC) to confirm the multimodal treatment plan, which was then discussed with Juana and her mother. The physician discussed medication options (SSRIs) and provided documentation (in both English and Spanish) from the visit to Juana's mother so she could initiate a school-based intervention with the Child Study Team at Juana's school. A plan for CBT—including a collaborative contingency management plan between the patient and her parent (eg, a reward chart for attending school) and exposure interventions (eg, a graduated plan to participate in school-based activities with the end goal to resume full school attendance)—was developed with the BHC. Biweekly follow-up appointments were scheduled with the BHC and monthly appointments were scheduled with the physician to reinforce the interventions. **JFP**

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tis usually is apparent when removing a patch and will resolve over a day, whereas allergic contact dermatitis forms over time and the skin rash is most prominent several days after the patch has been removed.¹

Treatment: First, stop the offense

Treatment of both variants of contact dermatitis includes avoidance of the causative substance and symptomatic treatment with topical steroids, antihistamines, and possibly oral steroids depending on the severity.¹

For our patient, a viral swab was taken and submitted for varicella zoster virus polymerase chain reaction testing to rule out persistent herpes zoster infection; the result was negative. The patient was counseled to discontinue use of the lidocaine patch.

Given the severity and protracted duration of the patient's symptoms, he also was

started on high-potency topical steroids (clobetasol 0.05% ointment to be applied twice daily under occlusion for 2 months), a 4-week prednisone taper (60 mg × 1 week, 40 mg × 1 week, 20 mg × 1 week, 10 mg × 1 week, then stop), and hydroxyzine (25 mg nightly as needed for pruritus). The patient's rash and symptoms improved dramatically within the first few doses of prednisone and completely cleared by Week 4 of the prednisone taper. At his follow-up appointment 1 month after completing the prednisone taper, he stated that the pain on his back had resolved. **JFP**

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