

# Solutions to school refusal for parents and kids

Pinpoint and address reinforcers of the child's behavior

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**N**athan, age 13, is referred by his parents for recent school refusal behavior. He has had difficulty adjusting to middle school and has been marked absent one-third of school days this academic year. These absences come in the form of tardiness, skipped classes, and full-day absences.

Nathan complains of headaches and stomachaches and says he feels upset and nervous while in school. His parents, however, complain that Nathan seems fine on weekends and holidays and seems to be embellishing symptoms to miss school. Nathan's parents are concerned that their son may have some physical or mental condition that is preventing his school attendance and that might be remediated with medication.

Child-motivated refusal to attend school or remain in class an entire day is not uncommon, affecting 5% to 28% of youths at some time in their lives.<sup>1,2</sup>

The behavior may be viewed along a spectrum of absenteeism (*Figure, page 68*), and a child may



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## School refusal

Figure

### A child might exhibit each behavior on this spectrum at different times

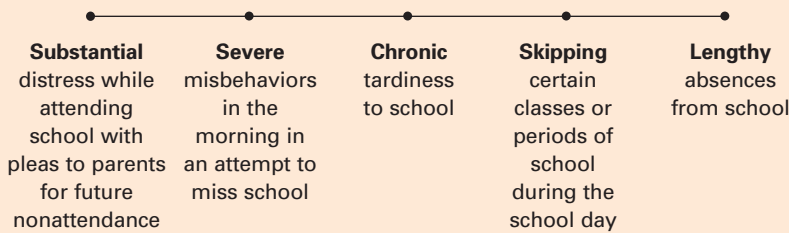


exhibit all forms of absenteeism at one time or another. In Nathan's case, for example, he could be anxious during school on Monday, arrive late to school on Tuesday, skip afternoon classes on Wednesday, and fail to attend school completely on Thursday and Friday.

In this article you will learn characteristics of school refusal behavior to watch for and assess, and treatment strategies for youths ages 5 to 17. You will also find advice and techniques to offer parents.

### REFUSAL BEHAVIOR CHARACTERISTICS

School refusal behavior encompasses all subsets of problematic absenteeism, such as truancy, school phobia, and separation anxiety.<sup>3</sup> Children and adolescents of all ages, boys and girls alike, can exhibit school refusal behavior. The most common age of onset is 10 to 13 years. Youths such as Nathan who are entering a school building for the first time—especially elementary and middle school—are at particular risk for school refusal behavior. Little information is available regarding ethnic differences, although school dropout rates for Hispanics are often considerably elevated compared with other ethnic groups.<sup>4,5</sup>

School refusal behavior covers a range of symptoms, diagnoses, somatic complaints, and

medical conditions (*Tables 1-3, pages 73-5*).<sup>6-12</sup> Longitudinal studies indicate that school refusal behavior, if left unaddressed, can lead to serious short-term problems, such as distress, academic decline, alienation from peers, family conflict, and financial and legal consequences. Common long-term problems include school dropout, delinquent

behaviors, economic deprivation, social isolation, marital problems, and difficulty maintaining employment. Approximately 52% of adolescents with school refusal behavior meet criteria for an anxiety, depressive, conduct-personality, or other psychiatric disorder later in life.<sup>13-16</sup>

### FINDING A REASON FOR SCHOOL REFUSAL

If a child has somatic complaints, you can expect to find that the child is:

- suffering from a true physical malady
- embellishing low-grade physical symptoms from stress or attention-seeking behavior
- reporting physical problems that have no medical basis.

A full medical examination is always recommended to rule out organic problems or to properly treat true medical conditions.

**Four functions.** If no medical condition is found, explore the reasons a particular child refuses school. A common model of conceptualizing school refusal behavior involves reinforcers:<sup>12</sup>

- **to avoid** school-based stimuli that provoke a sense of negative affectivity, or combined anxiety and depression; examples of key stimuli include teachers, peers, bus, cafeteria, classroom, and transitions between classes
- **to escape** aversive social or evaluative situations such as conversing or otherwise interacting

Box

## Is there a link between school violence and absenteeism?

**Violence on school campuses** across the country naturally makes many parents skittish about possible copycat incidents. In fact, some parents acquiesce to their children's pleas to remain home on school shooting anniversaries—particularly the Columbine tragedy of April 20, 1999.

Student and parental fears likely are exacerbated by new episodes of violence, such as three school shootings in 2006:

- On September 27, a 53-year-old man entered a high school in Bailey, Colorado, and shot one girl before killing himself.
- On September 29, a high school student near Madison, Wisconsin, killed his principal after being disciplined for carrying tobacco.
- On October 2, a heavily armed man barricaded himself in a one-room Amish schoolhouse in Paradise, Pennsylvania. He bound and shot 11 girls before killing himself, and five of the girls died.

Compared with highly publicized school violence, however, personal victimization is a much stronger factor in absenteeism.<sup>32</sup> Specifically, school violence is related to school absenteeism especially for youths who have been previously victimized. The literature shows:

- Students who have been bullied are 2.1 times more likely than other students to feel unsafe at school.
- 20% of elementary school children report they would skip school to avoid being bullied.<sup>33</sup>
- High school students' fear of attending classes because of violence is directly associated with victimization by teachers or other students.
- Missing school because of feeling unsafe is a strong risk factor for asthma and, potentially, being sent home early from school.<sup>34</sup>

with others or performing before others as in class presentations

- **to pursue** attention from significant others, such as wanting to stay home or go to work with parents

- **to pursue** tangible reinforcers outside of school, such as sleeping late, watching television, playing with friends, or engaging in delinquent behavior or substance use.

The first 2 functions are maintained by negative reinforcement or a desire to leave anxiety-provoking stimuli. The latter 2 functions are maintained by positive reinforcement, or a desire to pursue rewards outside of school. Youths may also refuse school for a combination of these reasons.<sup>17</sup> In Nathan's case, he was initially anxious about

school in general (the first function). After his parents allowed him to stay home for a few days, however, he was refusing school to enjoy fun activities such as video games at home (the last function).

**Assessment scale.** One method for quickly assessing the role of these functions is the School Refusal Assessment Scale-Revised.<sup>18,19</sup> This scale poses 24 questions, the answers to which measure the relative strength of each of the 4 functions. Versions are available for children and parents, who complete their respective scales separately (*see Related resources*). Item means are calculated across the measures to help determine the primary reason for a child's school refusal.

In addition to using the assessment scale, you may ask interview questions regarding the form

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identified differences in responses between elderly and younger patients. In general, a lower starting dose is recommended for an elderly patient, reflecting a decreased pharmacokinetic clearance in the elderly, as well as a greater frequency of decreased hepatic, renal, or cardiac function, and of concomitant disease or other drug therapy (see CLINICAL PHARMACOLOGY and DOSAGE AND ADMINISTRATION in full PI). Monitoring of orthostatic vital signs should be considered in patients for whom this is of concern. This drug is substantially excreted by the kidneys, and the risk of toxic reactions to this drug may be greater in patients with impaired renal function. Because elderly patients are more likely to have decreased renal function, care should be taken in dose selection, and it may be useful to monitor renal function (see DOSAGE AND ADMINISTRATION in full PI). **Concomitant use with Furosemide in Elderly Patients with Dementia-Related Psychosis:** In placebo-controlled trials in elderly patients with dementia-related psychosis, a higher incidence of mortality was observed in patients treated with furosemide plus risperidone when compared to patients treated with risperidone alone or with placebo plus furosemide. No pathological mechanism has been identified to explain this finding, and no consistent pattern for cause of death was observed. An increase of mortality in elderly patients with dementia-related psychosis was seen with the use of RISPERDAL<sup>®</sup> regardless of concomitant use with furosemide. RISPERDAL<sup>®</sup> is not approved for the treatment of patients with dementia-related psychosis. (See **Boxed WARNING, WARNINGS: Increased Mortality in Elderly Patients with Dementia-Related Psychosis.**)

**ADVERSE REACTIONS: Dose Dependency of Adverse Events:** Data from two fixed-dose trials provided evidence of dose-relatedness for extrapyramidal symptoms associated with risperidone treatment. These symptoms include: sleepiness, increased duration of sleep, accommodation disturbances, orthostatic dizziness, palpitations, weight gain, erectile dysfunction, ejaculatory dysfunction, orgasmic dysfunction, asthenia/lassitude/increased fatigability, and increased pigmentation. **Vital Sign Changes:** RISPERDAL<sup>®</sup> is associated with orthostatic hypotension and tachycardia (see PRECAUTIONS). **Weight Changes:** A statistically significantly greater incidence of weight gain for RISPERDAL<sup>®</sup> (18%) compared to placebo (9%). **Laboratory Changes:** A between-group comparison for 6- to 8-week placebo-controlled trials revealed no statistically significant RISPERDAL<sup>®</sup>/placebo differences in the proportions of patients experiencing potentially important changes in routine serum chemistry, hematology, or urinalysis parameters. Similarly, there were no RISPERDAL<sup>®</sup>/placebo differences in the incidence of discontinuations for changes in serum chemistry, hematology, or urinalysis. However, RISPERDAL<sup>®</sup> administration was associated with increases in serum prolactin (see PRECAUTIONS). **ECG Changes:** Between-group comparisons for pooled placebo-controlled trials revealed no statistically significant differences between risperidone and placebo in mean changes from baseline in ECG parameters, including QT, QTc, and PR intervals, and heart rate. When all RISPERDAL<sup>®</sup> doses were pooled from randomized controlled trials in several indications, there was a mean increase in heart rate of 1 beat per minute compared to no change for placebo patients. **Adverse Events and Other Safety Measures in Pediatric Patients With Autistic Disorder:** In the two 8-week, placebo-controlled trials in pediatric patients treated for irritability associated with autistic disorder (n=156), two patients (one treated with RISPERDAL<sup>®</sup> and one treated with placebo) discontinued treatment due to an adverse event. **Incidence of Treatment-Emergent Adverse Events in Two 8-Week Placebo-Controlled Trials in Pediatric Patients with Autistic Disorder. Body System Preferred Term: Psychiatric:** Somnolence, Appetite increased, Confusion **Gastrointestinal:** Saliva increased, Constipation, Dry mouth **Body as a whole - general:** Fatigue **Central & peripheral nervous system:** Tremor, Dystonia, Dizziness, Automatism, Dyskinesia, Parkinsonism **Respiratory:** Upper respiratory tract infection **Metabolic and nutritional:** Weight increase **Heart rate and rhythm:** Tachycardia **Other Events Observed During the Premarketing Evaluation of RISPERDAL<sup>®</sup>:** During its premarketing assessment, multiple doses of RISPERDAL<sup>®</sup> were administered to 2607 adult patients with schizophrenia and 1923 pediatric patients in Phase 2 and 3 studies and the following reactions were reported: (Note: frequent adverse events are those occurring in at least 1/100 patients; infrequent adverse events are those occurring in 1/100 to 1/1000 patients. It is important to emphasize that, although the events reported occurred during treatment with RISPERDAL<sup>®</sup>, they were not necessarily caused by it). Serious adverse reactions experienced by the pediatric population were similar to those seen in the adult population (see WARNINGS, PRECAUTIONS, and ADVERSE REACTIONS). **Psychiatric Disorders:** Frequent: increased dream activity\*, diminished sexual desire\*, nervousness. Infrequent: impaired concentration, depression, apathy, catatonic reaction, euphoria, increased libido, amnesia. Rare: emotional lability, nightmares, delirium, withdrawal syndrome, yawning. **Central and Peripheral Nervous System Disorders:** Frequent: increased sleep duration\*. Infrequent: dysarthria, vertigo, stupor, paraesthesia, confusion. Rare: aphasia, cholinergic syndrome, hypoesthesia, tongue paralysis, leg cramps, torticollis, hypotonia, coma, migraine, hyperreflexia, choreoathetosis. **Gastrointestinal Disorders:** Frequent: anorexia, reduced salivation\*. Infrequent: flatulence, diarrhea, increased appetite, stomatitis, melena, dysphagia, hemorrhoids, gastritis. Rare: fecal incontinence, eructation, gastroesophageal reflux, gastroenteritis, esophagitis, tongue discoloration, cholelithiasis, tongue edema, diverticulitis, gingivitis, discolored feces, GI hemorrhage, hematemesis. **Body as a Whole/General Disorders:** Frequent: fatigue. Infrequent: edema, rigors, malaise, influenza-like symptoms. Rare: pallor, enlarged abdomen, allergic reaction, ascites, sarcoidosis, flushing. **Respiratory System Disorders:** Infrequent: hyperventilation, bronchospasm, pneumonia, stridor. Rare: asthma, increased sputum, aspiration. **Skin and Appendage Disorders:** Frequent: increased pigmentation\*, photosensitivity\*. Infrequent: increased sweating, acne, decreased sweating, alopecia, hyperkeratosis, pruritus, skin exfoliation. Rare: bullous eruption, skin ulceration, aggravated psoriasis, furunculosis, verruca, dermatitis lichenoid, hypertrichosis, genital pruritus, urticaria. **Cardiovascular Disorders:** Infrequent: palpitation, hypertension, hypotension, AV block, myocardial infarction. Rare: ventricular tachycardia, angina pectoris, premature atrial contractions, T wave inversions, ventricular extrasystoles, ST depression, myocarditis. **Vision Disorders:** Infrequent: abnormal accommodation, xerophthalmia. Rare: diplopia, eye pain, blepharitis, photopsia, photophobia, abnormal lacrimation. **Metabolic and Nutritional Disorders:** Infrequent: hyponatremia, weight increase, creatine phosphokinase increase, thirst, weight decrease, diabetes mellitus. Rare: decreased serum iron, cachexia, dehydration, hypokalemia, hypoproteinemia, hyperphosphatemia, hypertriglyceridemia, hyperuricemia, hypoglycemia. **Urinary System Disorders:** Frequent: polyuria/polydipsia\*. Infrequent: urinary incontinence, hematuria, dysuria. Rare: urinary retention, cystitis, renal insufficiency. **Musculo-Skeletal System Disorders:** Infrequent: myalgia. Rare: arthrosis, synostosis, bursitis, arthritis, skeletal pain. **Reproductive Disorders, Female:** Frequent: menorrhagia\*, orgasmic dysfunction\*, dry vagina\*. Infrequent: nonpuerperal lactation, amenorrhea, female breast pain, leukorrhea, mastitis, dysmenorrhea, female perineal pain, intermenstrual bleeding, vaginal hemorrhage. **Liver and Biliary System Disorders:** Infrequent: increased SGOT, increased SGPT. Rare: hepatic failure, cholestatic hepatitis, cholecystitis, cholelithiasis, hepatitis, hepatocellular damage. **Platelet, Bleeding, and Clotting Disorders:** Infrequent: epistaxis, purpura. Rare: hemorrhage, superficial phlebitis, thrombophlebitis, thrombocytopenia. **Hearing and Vestibular Disorders:** Rare: tinnitus, hyperacusis, decreased hearing. **Red Blood Cell Disorders:** Infrequent: anemia, hypochromic anemia. Rare: normocytic anemia. **Reproductive Disorders, Male:** Frequent: erectile dysfunction\*. Infrequent: ejaculation failure. **White Cell and Resistance Disorders:** Infrequent: granulocytopenia. Rare: leukocytosis, lymphadenopathy, leucopenia, Pelger-Huet anomaly. **Endocrine Disorders:** Rare: gynecomastia, male breast pain, antidiuretic hormone disorder. **Special Senses:** Rare: bitter taste. \*Incidence based on elicited reports. **Postintroduction Reports:** Adverse events reported since market introduction which were temporally (but not necessarily causally) related to RISPERDAL<sup>®</sup> therapy include the following: anaphylactic reaction, angioedema, apnea, atrial fibrillation, cerebrovascular disorder, including cerebrovascular accident, diabetes mellitus aggravated, including diabetic ketoacidosis, hyperglycemia, intestinal obstruction, jaundice, mania, pancreatitis, Parkinson's disease aggravated, pituitary adenomas, pulmonary embolism, and precocious puberty. There have been rare reports of sudden death and/or cardiopulmonary arrest in patients receiving RISPERDAL<sup>®</sup>. A causal relationship with RISPERDAL<sup>®</sup> has not been established. It is important to note that sudden and unexpected death may occur in psychotic patients whether they remain untreated or whether they are treated with other antipsychotic drugs.

**DRUG ABUSE AND DEPENDENCE**

**Controlled Substance Class:** RISPERDAL<sup>®</sup> (risperidone) is not a controlled substance.

For more information on symptoms and treatment of overdose, see full Prescribing Information.

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Table 1

**Common symptoms that could signal school refusal behavior**

Internalizing/covert symptoms	Externalizing/overt symptoms
Depression	Aggression
Fatigue/tiredness	Clinging to an adult
Fear and panic	Excessive reassurance-seeking behavior
General and social anxiety	Noncompliance and defiance
Self-consciousness	Refusal to move in the morning
Somatization	Running away from school or home
Worry	Temper tantrums and crying

and function of school refusal behavior (Tables 4,5, page 76). Take care to assess attendance history and patterns, comorbid conditions, instances of legitimate absenteeism, family disruption, and a child's social and academic status. Specific questions about function can help narrow the reason for school refusal.

Assess specific school-related stimuli that provoke absenteeism such as social and evaluative situations, whether a child could attend school with a parent (evidence of attention-seeking), and what tangible rewards a child receives for absenteeism throughout the school day. Information about the form and function of school refusal behavior may also be evident during in-office observations of the family. Data from the School Refusal Assessment Scale-Revised,



Table 2

Primary psychiatric disorders among youths with school refusal behavior

Diagnosis	Percentage
None	32.9%
Separation anxiety disorder	22.4%
Generalized anxiety disorder	10.5%
Oppositional defiant disorder	8.4%
Major depression	4.9%
Specific phobia	4.2%
Social anxiety disorder	3.5%
Conduct disorder	2.8%
Attention deficit/hyperactivity disorder	1.4%
Panic disorder	1.4%
Enuresis	0.7%
Posttraumatic stress disorder	0.7%

Source: Reference 7

interviews, and observations can then be used to recommend particular treatment options.

TREATING YOUTHS WHO REFUSE SCHOOL

Treatment success will be better assured if you work closely with school personnel and parents to gather and share information, coordinate a plan for returning a child to school, and address familial issues and the child’s comorbid medical problems that impact attendance.

Medications have proven useful in alleviating severe cases of anxiety and depression, and cognitive management techniques can be applied to the child, the parents, and the family together.

Anxiolytics or antidepressants. Pharmacotherapy

research for school refusal behavior is in its infancy. Some investigators have found, however, that a tricyclic antidepressant (TCA) such as imipramine, 3 mg/kg/d, may be useful in some cases—generally for youths ages 10 to 17 years with better attendance records and fewer symptoms of social avoidance and separation anxiety. Researchers speculate that TCAs, which are not always effective in children, may influence symptoms such as anhedonia or sleep problems that contribute to school refusal behavior.

With respect to substantial child anxiety and depression without school refusal behavior, researchers have focused on selective serotonin reuptake inhibitors (SSRIs). In particular, fluoxetine, 10 to 20 mg/d, fluvoxamine, 50 to 250 mg/d, sertraline, 85 to 160 mg/d, and paroxetine, 10 to 50 mg/d, have been useful for youths with symptoms of general and social anxiety and depression.

Youths often do not respond to these medications as well as adults do, however, because of the fluid and amorphous nature of anxious and depressive symptomatology in children and adolescents. Careful monitoring is required when treating youth with SSRIs, which have been associated with an increased risk of suicidal behavior.

Psychological techniques. Sophisticated clinical controlled studies have addressed the treatment of diverse youths with school refusal behavior. Options for this population may be arranged according to function or the primary reinforcers maintaining absenteeism:

- child-based techniques to manage anxiety in a school setting



- parent-based techniques to manage contingencies for school attendance and nonattendance

- family-based techniques to manage incentives and disincentives for school attendance and nonattendance.

**Child-based** anxiety management techniques include relaxation training, breathing retraining, cognitive therapy (generally for youths ages 9 to 17), and exposure-based practices to gradually reintroduce a child to school. These techniques have been strongly supported by randomized controlled trials specific to school refusal behavior<sup>2</sup> and are useful for treating general anxiety and depression as well.

**Parent-based** contingency management techniques include establishing morning and evening routines, modifying parental commands toward brevity and clarity, providing attention-based consequences for school nonattendance (such as early bedtime, limited time with a parent at night), reducing excessive child questioning or reassurance-seeking behavior, and engaging in forced school attendance under strict conditions. Parent-based techniques have received strong support in the literature in general<sup>29</sup> but have been applied less frequently than child-based techniques to youths with school refusal behavior.

**Family-based** techniques include developing written contracts to increase incentives for school attendance and decrease incentives for nonattendance, escorting a child to school and classes, and

**Table 3**  
**Somatic complaints and medical conditions commonly associated with school refusal behavior**

Somatic complaints	Medical conditions
Diarrhea/irritable bowel	Allergic rhinitis
Fatigue	Asthma and respiratory illness
Headache and stomachache	Chronic pain and illness (notably cancer, Crohn's disease, dyspepsia, hemophilia, chronic fatigue syndrome)
Nausea and vomiting	Diabetes
Palpitations and perspiration	Dysmenorrhea
Recurrent abdominal pain or other pain	Head louse infestation
Shaking or trembling	Influenza
Sleep problems	Orodontal disease

teaching youths to refuse offers from peers to miss school.<sup>30</sup> As with parent-based techniques, family-based techniques have received strong support in the literature in general, but have been applied less frequently than child-based techniques to youths with school refusal behavior.

**School refusal behavior** sometimes is severe and intransigent and requires a multidisciplinary approach. This might include psychotherapy and medication. Cooperation and communication among parents, physicians, school officials, and mental health professionals is often crucial for resolving this difficult behavior.

**BottomLine**

continued



## School refusal

Table 4

### Questions related to *forms* of school refusal behavior

**What are** the child's specific forms of absenteeism, and how do these forms change daily?

**Is a child's** school refusal behavior relatively acute or chronic in nature (in related fashion, how did the child's school refusal behavior develop over time)?

**What comorbid conditions** occur with a child's school refusal behavior (*Table 3*), including substance abuse?

**What is** the child's degree of anxiety or misbehavior upon entering school, and what specific misbehaviors are present in the morning before school (*Table 2*)?

**What specific** school-related stimuli are provoking the child's concern about going to school?

**Is the child's** refusal to attend school legitimate or understandable in some way (eg, school-based threat, bullying, inadequate school climate)?

**What family** disruption or conflict has occurred as a result of a child's school refusal behavior?

**What is the child's** academic and social status? (This should include a review of academic records, formal evaluation reports, attendance records, and individualized education plans or 504 plans as applicable.)

Table 5

### Questions related to *functions* of school refusal behavior

**Have recent** or traumatic home or school events influenced a child's school refusal behavior?

**Are symptoms** of school refusal behavior evident on weekends and holidays?

**Are there** any nonschool situations where anxiety or attention-seeking behavior occurs?

**What specific** social and/or evaluative situations at school are avoided?

**Is the child** willing to attend school if a parent accompanies him or her?

**What specific** tangible rewards does the child pursue outside of school that cause him or her to miss school?

**Is the child** willing to attend school if incentives are provided for attendance?

## GRADUAL REINTRODUCTION TO SCHOOL

A preferred approach to resolve school refusal behavior usually involves gradual reintegration to school and classes. This may include initial atten-

dance at lunchtime, 1 or 2 favorite classes, or in an alternative classroom setting such as a guidance counselor's office or school library. Gradual reintegration into regular classrooms may then proceed.

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If possible, a child should remain in school during the day and not be sent home unless intense medical symptoms are present.<sup>30</sup> A recommended list of intense symptoms includes:

- frequent vomiting
- bleeding
- temperature >100° F
- severe diarrhea
- lice
- acute flu-like symptoms
- extreme medical conditions such as intense pain.

### CASE CONTINUED: A FULL-TIME STUDENT

A structured diagnostic interview and other behavioral assessment measures show that Nathan meets criteria for generalized anxiety disorder. He worries excessively about his social and academic performance at school and displays several somatic complaints related to anxiety. His treatment thus involves a two-pronged approach:

- sertraline, 50 mg/d, which has been found to significantly reduce symptoms of generalized anxiety disorder in youths ages 5 to 17.
- child-based anxiety management techniques and family therapy to increase incentives for school attendance and limit fun activities during a school day spent at home.

His therapist and family physician collaborate with school personnel to gradually reintroduce Nathan to a full-time academic schedule.

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### Related resources

- ▶ Copies of the child and parent versions of the School Refusal Assessment Scale-Revised are available at [www.jfponline.com/Pages.asp?AID=4322&UID=](http://www.jfponline.com/Pages.asp?AID=4322&UID=) or contact Dr. Kearney at [chris.kearney@unlv.edu](mailto:chris.kearney@unlv.edu).
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#### DRUG BRAND NAMES

Fluoxetine • Prozac	Paroxetine • Paxil
Fluvoxamine • Luvox	Sertraline • Zoloft
Imipramine • Tofranil	

#### ACKNOWLEDGMENT

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