Australian & New Zealand Journal of Family Therapy

Australian and New Zealand Journal of Family Therapy 2016, **37**, 528–546
doi: 10.1002/anzf.1188

Family Therapy for Child and Adolescent School Refusal

Katrina Richardson[1,2]

[1] *Alfred Child and Youth Mental Health Service, Moorabbin*
[2] *Private practice, Elsternwick*

Child and adolescent school refusal is a complex problem that can paralyse parents and professionals alike. Families often present in desperation, often after the problem has become well established. The literature concerning 'what works' is clear: addressing the problem early relates to better prognosis, and supporting the child to return to school is the primary priority. In practice, however, the 'how to' is often complicated by parental anxiety or complacency, complex family dynamics, therapist uncertainty about how to help, and poor partnerships between family and school. In this paper, I will present a framework for intervention informed by Structural and post-Milan ideas, developed from practice-based evidence – witnessing what works for families in everyday practice. A model for family therapy intervention is presented and discussed, illustrated with a case vignette.

Keywords: School refusal, systemic intervention, family therapy, youth, mental health

Key Points

1. The absence of a clear and universally accepted definition of school refusal makes it challenging to develop a thorough understanding of this complex problem.
2. There appears to be broad agreement in the literature that certain relational patterns are commonly seen in families of youth who school refuse. The dynamic of an overly close relationship between the school-refusing youth and one parent, with the other parent located as peripheral and disengaged, is very common.
3. The most prudent approach to treatment incorporates a 'dual focus' on the individual and the family. Developing an understanding of the *nature* of the young person's school refusal, as well as a systemic formulation of the family dynamics relevant to the development and maintenance of the problem, are essential for effective treatment.
4. Systemic intervention involves broadening the focus of treatment beyond the nuclear family to include the school system, extended family and community supports. In the absence of a collaborative partnership between school, family, and treating team successful treatment is unlikely.
5. Therapists should be mindful of factors that may further complicate treatment, such as when the young person has a gaming addiction or suicidal ideation, and assertively address these issues as they arise. Working with separated parents requires the therapist to elicit agreement from parents to work together in the best interests of the young person.

> 'The problem starts with vague complaints of school and reluctance to attend, progressing to total refusal to go to school or remain in school in the face of persuasion, entreaty, recrimination and punishment … The behaviour may be accompanied by overt signs of anxiety or even panic … Characteristically, they remain at home with their parents knowledge when they should be at school.'
>
> Hersov (1985; cited in Bryce & Baird, 1986)

Address for correspondence: katrina.alford@icloud.com

School refusal is a serious problem that affects approximately 1% to 5% of all school-aged children. Prevalence rates are similar across genders, and it tends to be more common in children around 5 years and 10 years of age. Onset is usually gradual, and comorbid depression or anxiety is common (Fremont, 2003). Short-term consequences include academic difficulties, peer relational problems, and family problems; long-term consequences include academic underachievement, poorer occupational and employment outcomes, and increased risk of adult psychiatric problems (Bernstein, Warren, Massie, & Thuras, 1999; Flakierska-Praquin, Lindstrom, & Gillberg, 1997). School refusal can serve a range of functions, including avoidance of specific school-based fears (e.g., exams), avoidance of social situations, separation anxiety, securing parental attention, or other relational functions. Problematic family dynamics correlated with school refusal include enmeshment/over-dependency, disengagement, a high degree of conflict, and family isolation (Kearney & Silverman, 1995). It differs from truancy in several important ways: truancy is generally characterised by the absence of anxiety about attending school, attempts to hide non-attendance from caregivers, and the presence of antisocial behaviours such as stealing or drug use. The prognosis is generally good if school refusal is addressed early, but is much poorer once the problem is well established (Fremont, 2003).

In this paper, I will present my framework for systemic intervention for the treatment of child and adolescent school refusal, illustrated with a detailed case vignette. I've developed these ideas from my preferred ways of working, and practice-based evidence – what works for families. I've drawn heavily on Structural and post-Milan ideas. I've also been informed by the Maudsley Model for Treatment of Anorexia Nervosa, also known as Family-Based Treatment (FBT) (Rhodes, 2003). Although anorexia and school refusal are different problems, I think they are similar in what they require of parents for their resolution – that is, for parents to orchestrate a deliberate interruption to the young person's developing autonomy and assume responsibility for managing the aspect of life the young person is unable to manage themselves, whether it be eating or school attendance (Allan & Power, 2011; Rhodes, 2003).

Understanding School Refusal

Within the existing body of research, there is little agreement about how school refusal is defined. Several authors appear to use the terms 'school refusal,' 'school phobia,' and 'truancy' interchangeably (Bernstein et al., 1999; Kearney, 2006; Ek & Eriksson, 2013); while others draw a distinction between school refusal and truancy, the latter more commonly associated with conduct disorder and antisocial behaviour (Hawkes, 1981, 1982; Lang, 1982; Bryce & Baird, 1986; Fremont, 2003; Kearney, 2008; Heyne, Sauter, Ollendick, Van Widenfelt, & Westenberg, 2014). The absence of a clear and universally accepted definition makes it difficult to develop a thorough understanding of this complex problem (Kearney, 2008).

The interchangeable use of the terms 'school refusal' and 'school phobia' might lead to the erroneous belief that all school refusal is anxiety-based, when this is not always the case. This narrow definition of the problem excludes those young people whose school refusal may be primarily an expression of family dysfunction (Bernstein & Borchardt, 1996; Bernstein et al., 1999; Hawkes, 1981, 1982; Lang, 1982; Menahem & Cebon, 1984; Relph, 1984), such as a dilemma 'around the need for closeness

versus the challenge of a growing sense of differentiation of family members' (Hawkes, 1982, p. 130).

Among school-refusing youth psychiatric comorbidity is common, with anxiety and depressive disorders the most prevalent (Bernstein et al., 1999; Egger, Costello, & Angold, 2003; Ek & Eriksson, 2013; Fremont, 2003; Heyne et al., 2014; Lang, 1982). Several authors also identify a number of contextual risk factors for child and adolescent school refusal, including parental mental illness (Egger et al., 2003); isolation and low levels of engagement in extra-familial activities (Kearney & Silverman, 1995); single-parent or stepparent households (Bernstein & Borchardt, 1996); parental unemployment, family violence (Egger et al., 2003); poverty (Egger et al., 2003; Kearney, 2008); teen pregnancy, school violence and victimisation, school connectedness (Kearney, 2008).

When school refusal is understood as intimately related to family dynamics there appears to be general consensus that certain relational patterns are commonly seen in families of youth who school refuse – namely, the dynamic of an overly close relationship between the school-refusing youth and one parent (usually the mother) while the other parent is disengaged and peripheral (Bryce & Baird, 1986; Hawkes, 1981, 1982; Kearney & Silverman, 1995; Lang, 1982; LeUnes & Siemsglusz, 1977). Furthermore, families of school-refusing youth are often less flexible and cohesive, and somewhat insular, with a rigid boundary around the family. The physical and/or psychological separateness of the child is often also tacitly discouraged (Bernstein et al., 1999; Kearney, 2008; Kearney & Silverman, 1995).

While there is variability in how school refusal is conceptualised, there is consensus regarding the need to understand the primary function of the behaviour (e.g., to secure parental attention, avoid anxiety-provoking stimuli at school, to stabilise the family system in the context of change) in order to provide effective treatment (Egger et al., 2003; Ek & Eriksson, 2013; Fremont, 2003; Ginsburg, Silverman, & Kurtines, 1995; Heyne et al., 2014; Kearney, 2006, 2008; Kearney & Silverman, 1995; Relph, 1984). The literature stresses the importance of thorough assessment and a detailed formulation of the problem (Bryce & Baird, 1986; Egger et al., 2003; Ek & Eriksson, 2013; Fremont, 2003; Heyne et al., 2014; Kearney, 2006, 2008; Kearney & Silverman, 1995; Lang, 1982; Relph, 1984).

The presence of depressive and anxiety disorders in school-refusing youth appears to lead some authors to conclude that individually focused Cognitive Behaviour Therapy (CBT) should be the primary treatment of choice (Egger et al., 2003; Ek & Eriksson, 2013; Ginsburg et al., 1995; Heyne et al., 2014; Kearney, 2006), especially given the substantial evidentiary support for CBT in the treatment of depression and anxiety (Ginsburg et al., 1995). However, others eschew a focus on the individual and give primacy to family/systemic interventions (Bernstein et al., 1999; Bryce & Baird, 1986; Hawkes, 1982; Kearney & Silverman, 1995). Perhaps the most prudent approach to treatment incorporates a 'dual focus' on the individual and family (Lang, 1982; Relph, 1984; Fremont, 2003; Kearney, 2008). The literature also emphasises the importance of working collaboratively with the school system to facilitate the young person's return to school and to guard against problematic dynamics within the family being replicated within the broader system of the family/school/treatment team (Bryce & Baird, 1986; Egger et al., 2003; Ek & Eriksson, 2013; Fremont, 2003; Hawkes, 1981; Heyne et al., 2014; Kearney, 2006, 2008; Kearney & Silverman, 1995; Lang, 1982; LeUnes & Siemsglusz, 1977; Relph, 1984).

Why is Family Therapy the Treatment of Choice?

The primary treatment for school refusal is for the young person to return to school as early as possible (Fremont, 2003). Very few – if any – young people are motivated and capable of overcoming their anxiety and returning to school on their own, hence the need for systemic intervention. In essence, effective treatment involves exposure (attending school), which usually requires parents to make this happen (Allan & Power, 2011). Carr (2009) found that behavioural family therapy results in recovery for two-thirds of families treated, which is significantly greater than rates of improvement for individual child therapy. In order for change to be lasting, it is recommended that treatment address 'family dysfunction' and problem-maintaining patterns of interaction within the nuclear family (Fremont, 2003). Behavioural family therapy has been found to be equally effective without the child receiving direct individual intervention (Fremont, 2003), suggesting the effective elements of treatment lie in a systemic and family therapy intervention. In the following, I present a detailed *case vignette* including my reflections on a systemic family therapy approach.

My Work Context

I work part-time as a senior clinician with the Alfred Child and Youth Mental Health Service. The service works systemically with 0–25 year olds experiencing serious and complex mental health issues, and their families. Referrals for young people presenting with school refusal are common. We treat school refusal with the same urgency as suicidal ideation, as we know the longer the problem endures, the worse the prognosis of the young person and family. Treatment is systemic, never individually focused. I also work part-time in private practice; my approach to treatment is similar, regardless of the treatment context.

Case Vignette

> The Black family[1] self-referred seeking assistance for Jane, aged 17 years. Jane was the younger of two daughters born to Terry and Ann. Her older sister, Amy, aged 19 years, was studying at university and still living at home.
>
> Jane had been school refusing 3–4 days a week for almost 2 years. Jane did well academically but school were frustrated by her poor attendance and were considering exiting her for reasons of poor participation. Onset had been gradual; Jane's attendance began to decline after she returned to school following a period of absence due to illness. This coincided with Jane commencing VCE, and Amy commencing university and spending less time with the family.
>
> Terry and Ann had taken Jane to several individual therapists, however treatment had not been effective. On this journey, Jane had collected a variety of psychiatric diagnoses including major depression, OCD, Chronic Fatigue Syndrome, and Generalised Anxiety Disorder. Terry and Ann had been advised by several professionals not to push Jane to attend school because she would begin attending when she 'felt better.'
>
> The family was initially seen for a single session family consultation by me, a co-therapist, and a reflecting team. I then continued working with the family alone.

A Systemic Formulation of the Problem

School refusal is complex and multifactorial. As such, it is important to develop a detailed formulation of the contributions of various intrapersonal, interpersonal, and systemic factors in order to develop an effective treatment plan (Lang, 1982, p. 106). My formulation is developed in collaboration with the family and is, in essence, a systemic formulation of the difficulties combined with an understanding of the *nature* of the school refusal.

School refusal is an externalising problem (a difficulty manifest in a young person's outward behaviour), which suggests a lack of parental unity or consistency, and the possibility of a coalition between the young person and a parent (James & MacKinnon, 2011). Lang (1982) suggests 'poorly functioning parental, spouse and sibling sub-systems should be suspected.' I also consider whether the problem serves some kind of function for the family; for example, does the focus on the child serve to diffuse tension in the couple? The next question I ask is why the problem has occurred at this particular point in time rather than some other. Problems often emerge in response to changes in the family system: is the problem a 'solution' to some other problem within the family (Wallis & Rhodes, 2011)?

When considering the nodal point, I find the concept of vertical and horizontal stressors useful in helping me to consider what contributing systemic factors may be at play. Horizontal stressors are associated with developmental transitions and include anticipated stressors such as children leaving home, and unpredictable stressors such as family deaths, or job loss (Carter & McGoldrick, 1999). Vertical stressors are intergenerational patterns of relating and functioning, including family norms, attitudes, and expectations, usually passed down through generations (Carter & McGoldrick, 1999). Identifying the family dynamics that function to reduce anxiety by maintaining homeostasis helps me to understand what keeps the problem going. It also helps to promote the family's development of a circular (vs. linear) understanding of the problem (Rhodes, 2008), which sets the scene for the whole family's participation in the process of change. Exploring past attempts at solutions also yields valuable information about family functioning (Bryce & Baird, 1986).

> The 'nodal point' for the Black family appeared to be related to a family life cycle transition: Amy completing school and becoming more separate from the family. Jane's school refusal also provided a shared focus for Terry and Ann, without which I suspected the couple's marital tensions threatened to come to the fore.
>
> Jane's school refusal caused conflict between Terry and Ann. There was evidence of a soft/hard split between the parents and a coalition between Terry and Jane to the exclusion of Ann. Ann developed an alliance with Amy, who acted as her confidante and, at times, 'co-parent.' This created conflict between Amy and Jane: Amy resented Jane for the stress she caused in the family; Jane resented Amy for 'taking Mum and Dad's side.'

To understand the nature of the young person's school refusal, I try to determine if the refusal to attend school is driven primarily by a desire to avoid something in the school setting or by a desire to stay home. In some ways, this is a somewhat artificial delineation as often it's a complex interplay between both home- and school-based issues that contribute to the development and maintenance of the problem. If the issues are home-based, I focus on addressing the issues leading to the young person's wish to stay home. If, for example, the young person is anxious about parental

conflict, I focus on addressing the marital issues by making these issues a focus of discussion in parent therapy or family therapy sessions. If the primary issue is separation anxiety, I support parents to help their young person tolerate increasingly lengthy periods of time away from home/parents.

If the issues are school-based, I focus more attention on the school setting. Some common school-based difficulties underlying refusal to attend are learning problems and social difficulties (Allan & Power, 2011). Addressing academic issues may involve liaising with the school to arrange formal cognitive testing, reducing academic demands, or modifying the curriculum. For a child who lacks social confidence or competence, parents can provide the child with 'practice' through play-dates, extra-curricular activities, sports, or clubs. School can scaffold social interactions and sometimes provide additional support, for example through the provision of semi-structured social activities at break times or small group work in class.

> Jane's school refusal was driven by anxiety about academic performance and a fear of failure. School and parents had noticed that Jane's anxiety escalated (and attendance declined) in the lead-up to an exam or assessment. Jane stayed home, studied excessively, went to school and 'aced' her assessments then resumed school refusing. This enabled Jane to avoid the negative academic consequences of non-attendance; however she remained 'stuck' in a repetitive pattern of avoidant behaviour that reinforced her non-attendance and concurrent anxiety.

Raise Awareness About the Seriousness of the Problem

I have found that many parents tend to perceive the problem of school refusal in terms of adverse academic outcomes, and perhaps poor social outcomes. I try to broaden their focus by reframing school attendance as 'practice at life': school is a training ground for the development of social and life skills. A young person who is not able to attend school risks becoming stunted in most areas of their development, in addition to risking adverse academic, social, and psychiatric outcomes (Fremont, 2003). I prompt parents to consider what the young person's future might look like if they do not address the issue; how they foresee the young person's development progressing should they continue to refuse to engage in school, and later work; what it might be like for the family to have the young person remain at home for years to come. Often this line of questioning helps the family to grasp the serious implications of continued school refusal, while at the same time highlighting the possibility that the family may be ambivalent about change (Bryce & Baird, 1986).

> Terry and Ann were uncertain how seriously to take the problem because Jane continued to achieve high grades and lead a healthy social life. We talked about the prognosis and risks of untreated school refusal. I prompted the parents to consider how this pattern of behaviour, should it continue, might impact Jane's plans for university and employment. We talked about the problem not as one of school attendance, but as one of 'skill development': Jane needed to develop the skills of managing anxiety, and her own high expectations, along with the other demands of advanced adolescence.
>
> This redefinition of the problem really seemed to resonate with the parents, particularly Terry, who became more visibly engaged during this discussion. (My hypothesis was that Terry felt powerless to effect change when he understood the problem as being psychiatric, but as a caring father felt more able to help his child develop needed

'skills'). He became more active in sessions, started making suggestions to Ann about what to do, and became more involved in managing the problem at home.

Harness Parental Anxiety

If the problem becomes chronic, I often find parents become stuck in reactive ways of responding, or are so anxious about it they become paralysed and unable to act. I try to moderate parental anxiety to activate the parents and prepare them for the difficult task of returning the young person to school. Insisting the parents return the young person to school, which circumvents avoidance and leads to a crisis within the family, is necessary for change to occur (Bryce & Baird, 1986). Without the 'crisis,' the family can continue to avoid addressing the problematic dynamics that maintain the problem (Bryce & Baird, 1986). A crisis brings these dynamics 'out into the open.'

This is my way of thinking about two different ways parents often present. Obviously this is a gross over-simplification, but I find it helps me to think about which aspects of intervention to emphasise with which families:

- *Overanxious-inert* parents present as paralysed by anxiety and feel unable to take action. They benefit from an emphasis on the task of school return being broken down into small steps, and being supported to act. I maintain urgency, but proceed slowly. My aim is to support these parents to do *something* (rather than continuing to do nothing).
- *Overanxious-reactive* parents benefit from an emphasis on being restrained from engaging in the repetitive, reactive responses that have become habitual but do not fix the problem.

When both parents are overanxious, I work to contain anxiety by being more directive and providing more structure (e.g., clear treatment plan, regular appointments, frequent contact, and the early establishment of a partnership with school). Sometimes parents have become so used to the problem they have lost their anxiety about it! When parents are under-anxious, I tend to spend more time emphasising the seriousness of the problem and prompting the family to consider the implications of not changing, in an effort to raise their anxiety and prompt them to act (Bryce & Baird, 1986).

Sometimes complementarity in the parents' roles may extend to the degree of anxiety each has about the problem. My experience is that excessive anxiety in one parent often occurs in response to a perceived – or actual – absence of it in the other parent, and this is most likely to occur if there is a 'soft–hard' split: when the firm approach of one parent elicits a more gentle approach from the other, in a reciprocal pattern (James & MacKinnon, 2011). The 'tough' parent becomes increasingly anxious and rigid in their dealings with the young person while the 'soft' parent is reciprocally complacent and permissive. Here, I believe the therapist's task is to reduce the complimentary in the parents' positions by increasing parental unity and consistency (James & MacKinnon, 2011). This seems to function to restrain the overanxious parent and activate the under-anxious one; in essence, helping the parents to regulate each other.

While Ann presented as 'overanxious-reactive,' Terry was not anxious enough. Ann tried to force Jane out of bed and off to school but often became aggressive. Terry

avoided involvement until the interaction became a screaming match, when he would intervene by directing Ann to 'give in' and allow Jane to stay home as he found the conflict intolerable. Ann, feeling unsupported by Terry, became angrier with Jane and intensified her focus on the school problem. Terry became less supportive towards Ann and more accommodating towards Jane.

Terry was encouraged to be more supportive of Ann and more active in managing the problem, which helped contain Ann's anxiety. Ann was encouraged to allow Terry to take an equal role managing the problem. Terry and Ann became less reactive to one another and more considered in their approach, and ceased engaging in the repetitive patterns that maintained the problem. Ann allowed Terry to take responsibility for getting Jane to school, while she supported him calmly.

Debunk Family 'Myths' About the Problem

'She has to feel ready before she can return to school.'

'If we force her, we'll make her worse.'

'She'll go back to school when her depression is better.'

I think this is a really an important part of successful treatment. It's common for families to view school refusal as medical or psychiatric (Bryce & Baird, 1986). Somatic symptoms of anxiety such as gastrointestinal disturbance or headaches are given undue credence and used to account for the inability to attend school. Depression – which is often helped, if not cured, by a return to usual routine – is offered up as the rationale for non-attendance. Reframing school refusal in developmental terms serves to relocate the problem within the family's sphere of influence – as a problem of 'growing up' and skills development (Bryce & Baird, 1986). While parents may feel powerless to help a young person with a mysterious illness or complicated psychological problem, they often feel much better equipped to help their child grow up.

Family members often have differing views of the problem, and/or disagree about how to address it (Bryce & Baird, 1986). I believe it is helpful to overt conflicting 'formulations' because the absence of a shared understanding of the problem can easily derail treatment. If parents have differing perceptions of the problem it will be very difficult to get them to work together. I find it helpful to draw on post-Milan ideas here: I use circular questions to elicit similarities and differences in family members' perceptions of the problem, degree of concern, and ideas about how to address it (Wallis & Rhodes, 2011).

When the young person who is school refusing presents as depressed or withdrawn, I have found that parents are often anxious about pushing the young person to attend school for fear they may harm themselves. I believe that as long as the specter of suicide lurks in the background, the parent's anxiety is likely to prevent them being forceful enough to get their young person back to school. In order to make the unspeakable speakable, I ask parents if they are worried their young person will kill themselves if they push too hard. From here, a conversation about how to manage risk becomes possible (see 'Special Considerations' below).

The dominant family 'myth' was that Jane's various psychiatric diagnoses prevented her from going to school. I asked the family if they could think about the problem a little differently: rather than waiting for Jane's depression/OCD/CFS/anxiety to resolve

before she could attend school, was it possible that a return to being a normal adolescent (school) might make Jane happier? We talked about the ways Jane's social and emotional development was threatened by this problem. I asked the parents to consider what Jane's future might look like if she learned the habit of 'giving in' to anxiety when she felt fearful of failing. I asked how this might affect Jane's willingness to tackle new challenges in future.

Strengthening the Parental Subsystem and Aligning the Siblings

School refusal can be understood as a consequence of a poorly functioning executive subsystem in which parents exercise inadequate authority and control (Lang, 1982). The key message I want to give parents is: *how* you do it is less important than *doing it together*. Often there is a 'soft–hard' split between the parents and a cross-generational coalition between the child and one parent (James & MacKinnon, 2011). How the parents go about getting their child to school is far less important than the parents being able to support one another and act together. This serves to strengthen the functioning of the parental subsystem and weaken the coalition between parent and child (where one exists). The overarching goal of aligning parents and supporting them to work together more effectively to return the young person to school is to 'reshape over- and under-involved parent-child relationships into those with more appropriate and clearly defined boundaries' (Kearney & Silverman, 1995, p. 68).

In the first session, I ask the parents to talk with one another about how they will get the young person back to school. This enactment allows me to observe family dynamics in action, interrupt negative relationship patterns, and provide direct coaching (James & MacKinnon, 2011). I provide direct feedback about things I notice the parents doing that appear to be preventing them from working together (e.g., consulting with the young person rather than each other), and those that seem to support them working together effectively (e.g., ignoring the young person's objections and problem-solving together). The next step is to support the parents to formulate a *detailed plan* for getting their young person back to school. I persist in questioning the parents until they develop a clear and detailed picture of what they intend to do, in addition to prompting parents to anticipate possible hurdles and plan for them (Bryce & Baird, 1986).

In order to return the young person to school, parents must tackle the young person's resistance directly and overcome it (Hawkes, 1981). I usually forewarn parents the problem will get worse before it gets better, and invite them to consider how they will manage increased resistance from their young person. I might make tentative suggestions based on my own experience and what other families have found helpful. In subsequent sessions, I focus on isolating small changes and plotting the 'virtuous cycle.' (Rhodes, 2008). I identify any shifts parents have made in taking control of the problem, becoming more unified in their approach, working together more effectively, making small movements towards getting their young person back to school. I explore the effects of these changes on every family member, in order to highlight everyone's role in creating change.

The sibling relationship is often strained by the young person's school refusal, for a variety of reasons. There may be jealousy from the sibling who still has to attend school, and it is not uncommon for siblings to school refuse in order to garner more parental attention (Kearney & Silverman, 1995). The sibling may feel drawn into a

co-parent role, particularly in single-parent households. In the case of a coalition between the young person and a parent, the sibling may align with the other parent, in effect causing the family to be 'split down the middle.' A coalition between parent and young person often excludes not only the other parent, but siblings, too, negatively affecting the functioning of the sibling subsystem (Lang, 1982). Kearney and Silverman (1995) caution the therapist to be alert to 'ripple effects' of disturbance in other dyads (such as the sibling relationship) which are secondary to the primary relational disturbance present in between young person and parents.

Strengthening the siblings relationship is essential to guard against the young person feeling isolated within the family, as their parents become firmer and they are excluded from the executive subsystem. When forced to return to school, the young person is being forced to confront very real anxiety. This is hard enough. The support of a sibling can make all the difference. I might encourage the sibling to look for ways to be 'soft' with the young person while the parents get 'tough,' such as offer to talk or do things together they used to enjoy before the problem got in the way. I might ask the sibling to trust parenting to Mum and Dad, and coach the parents to thank the sibling before giving the message they are capable and can be trusted with this task. I might ask the parents to be mindful not to voice their frustrations to the sibling and exclude them from any discussions concerning the young person's return to school.

Sometimes a sibling is so hurt or angry they are unable to take up this role. For example, they may be angry with the young person for the pain they have caused the parents, or hurt by what they perceive to be 'special treatment' received from parents. In this instance, I create space for the sibling to speak in detail about the ways they have been affected by the problem and what they need from their parents but have not yet received (Levy, Creed, & Diamond, 2001). I coach parents to acknowledge the sibling's concerns, offer apology if necessary, and make commitments to repair the relationship in whatever ways are needed (Levy et al., 2001). Sometimes this can happen in a whole family session; sometimes a separate session with sibling and parents alone may be needed. I've found that once the sibling has been acknowledged in this way, they are usually able to take up a supportive role.

> Terry and Ann agreed their aim was to return Jane to full-time school but became polarised in their attempts to achieve this. Using circular questioning, I elicited a detailed behavioural sequence around one of the worst mornings. I instructed the parents to talk together in session about how they could work together more effectively. During this discussion, Amy began to offer advice. I blocked her interruptions and encouraged parents to persist. Terry began to consult Jane and seek her agreement; I redirected him to talk with Ann instead. Terry and Ann successfully negotiated a plan they could carry out together.
>
> In a later session, Amy revealed that Jane had been trying to 'chat' to her on social media about how angry she was at their parents. Amy had rebuffed her. We talked about what Jane's desire to connect with her might mean, and Amy realised she was probably feeling isolated because Terry and Ann had become firmer with her and Amy was busy with her boyfriend. Amy felt her anger towards Jane had been getting in the way of the two of them talking like they used to.
>
> At this point, Ann revealed she often complained to Amy about Jane and realised this probably fostered conflict between the girls. I suggested Amy focus on being a sister

and trust Terry and Ann with the job of parenting, and we talked about how she might do this. I suggested Ann take her complaints to Terry instead of Amy; she agreed to try.

Recruit the Young Person as an Ally

This is dependent on the age of the young person, of course, but children of most ages and all adolescents can usually be involved in the return to school plan in some way. A younger child might not attend school meetings, for example, but might be given the choice of which teacher they would like to act as a support person if they are finding it tough at school (Allan & Power, 2011). Adolescents can be invited to school meetings with parents, school, and treating team. They can be asked what supports they would like at school, what they want teachers to be aware of, and how they would like their period of absence explained to teachers and pupils. If a graduated return is planned, young people might name their preferences for which subjects to begin attending first (parents maintain veto rights, of course).

School refusal can be seen as causing an interruption to normal adolescent development. Involving the young person as an active participant can act as an antidote to parents' temporarily overriding the adolescent's developing autonomy by taking control of school attendance. Maximising the young person's power and choice – within appropriate limits – can help to minimise resentments and the development of an adversarial 'us and them' dynamic (Allan & Power, 2011).

Parents can be encouraged to talk with their young person about their desire to handover control as soon as possible, and to specify what they would need to see from the young person in order to do this (e.g., full-time attendance for a specified period of time).

Jane attended the first family therapy session only. I asked Jane about her motivations for returning to school and sought to maximise her sense of autonomy by posing questions like, 'What are your ideas about the best ways for you to get back to school?'

'I know you find it really hard to go to school – and I doubt you're going to like Mum and Dad forcing you to go – but they're going to do it anyway. Can you give them any tips about how to make it easier for you?'

'If you were at school and started to find it tough, what kind of support (at school) would help?'

I explored how each person in the family was affected by the problem, to highlight the shared experience of struggle. This served to align Jane with the rest of her family: the Black family versus the problem of school refusal (instead of Terry and Ann versus Jane).

Broaden Your Understanding of the System

I think of school and family as two subsystems embedded within a larger system and subject to the usual dynamics such as alliances, triangles, and recursive patterns of interaction (Allan & Power, 2011). The family can influence the school's functioning and vice versa. The school can replicate the dynamics of the family, in a similar form of parallel process that can occur between family and therapist (Wallis & Rhodes,

2011). I conceptualise the alliance between school and family as similar to a parental relationship. If the 'Mum and Dad' (school and parents) are not working together it's easy for the young person to get caught in the middle. An effective parenting team has shared goals, works together, and doesn't argue in front of the children! I work hard to develop the alliance between family and school by establishing open communication as early in treatment as possible. I meet with the family and school counsellor to negotiate a return to school plan and establish a protocol for regular communication (e.g., email, conference calls, Skype).

If the problem is chronic, there may be a build-up of resentments on the part of both parents and school. Parents may perceive school as not offering enough guidance; school may perceive parents as laissez-faire or ineffective. If this persists, the relationship between family and school becomes increasingly strained, communication breaks down, and the two sub-systems become reactive to one another. Young people can perpetuate this 'split' (usually by complaining to parents about school and vice versa) in the interest of remaining at home. Usually a poor relationship between family and school can be rectified with improved communication. I've found that when school and family become aware of just how much effort each is investing in trying to return the young person to school, greater empathy and collaboration becomes possible. The therapist is uniquely placed to facilitate such 'healing conversations.'

I also look to the extended family, social network, and community to explore what additional supports may be helpful to the family. Extended family may be able to provide respite for stressed parents or engage the young person in quality-time activities (not in school time, of course). In the case of single-parent families, an extended family member might come to the home of a morning and assist with getting the young person to school. A school friend may be able to walk the young person to school or sleep over the night before. Family support agencies may assist families struggling with financial strain, parental mental illness, or other psychosocial stressors, to enable parents to wholly focus their attention on returning the young person to school.

I will provide parents with brief phone coaching between sessions as requested. I think this conveys a powerful message of support, and parents have let me know they really value having a sense that they aren't on their own. If parents have made several unsuccessful attempts to get the young person to school, I might go to the home in the morning and provide 'in vivo' coaching. I never intervene directly, to avoid undermining the parents' authority.

> I established communication with the school counsellor following the first family session and we continued to liaise by phone and email. The school counsellor acted as liaison between me, the family, and the school community. She developed a return to school plan in collaboration with the family and myself and met with Jane alone to problem-solve practical difficulties like missed assessments.
>
> Some days, Ann was unable to contain her anxiety about Jane's refusal to attend and would call school several times a day. This created anxiety among school staff. The school counsellor and I agreed that Ann should be redirected to contact me, which contained Ann and the school.
>
> I noticed a parallel process between parents and school: sometimes when her parents increased pressure on Jane to attend school she threatened to run away, which increased Terry and Ann's anxiety and temporarily induced them to be more lenient. Similarly,

when school held firm regarding attendance or submission of work Jane threatened to quit school and intimated she felt 'life was not worth living.' This had the effect of undermining the school's confidence in the treatment plan. I managed this by sharing my observations with the school counsellor about the parallels between home and school, and explaining the rationale for the current treatment plan. This strengthened our alliance and reassured school. We also talked about what school should do if Jane escalated to threats of suicide, which turned out to be their biggest concern.

Several times during treatment, Ann and Terry utilised the support of extended family, sending Jane for brief 'respite' stays with relatives. Early in treatment, I provided phone coaching between sessions on a regular basis.

Outcomes

My experience is systemic family therapy for the treatment of school refusal tends to be most effective with younger children, when the problem is not well established, and when pre-morbid family functioning is high. Treatment seems to be more challenging when there are significant pre-morbid difficulties in family functioning, when school refusal is complicated by computer addiction, and/or the young person has a reversed sleep cycle or other sleep disorder. As mentioned above, treatment is made more difficult when the young person presents with suicidal ideation, as parental anxiety about risk often becomes a barrier to parents firmly insisting on the return to school. However, I believe the single most important factor in successful treatment is my alliance with the parents and their willingness to take a firm, authoritative approach to returning their young person to school. If parents are unwilling or unable to take up this role, treatment is difficult.

Terry and Ann were successful in getting Jane back to school. Jane quickly became annoyed by her parent's control and supervision, and took responsibility for getting herself out of bed and to school. Several times during treatment, Terry and Ann had to resume this responsibility as Jane started to miss days. When her parents stepped in, Jane's attendance quickly improved. As predicted, Jane's mental health did improve following her school return. She finished her VCE year with plans to commence university the year after.

The Family's Reflections on Treatment

I asked for the family's reflections on treatment, and they provided the following:

'It's great that you can offer this, because as a parent, you start to doubt yourself . . . doubt that you are doing the right thing. Then we can come in and talk to you and be reminded that we are on the right track.' (Mum)

'It's exhausting. It (family therapy) gives you the energy to keep going. . .. It's like an adrenaline shot.' (Mum)

'As a parent you begin to wonder if by pushing her to go to school you're doing the right thing . . . that reassurance is really important.' (Dad)

'Coming here and talking about it helps me to realise things are getting better. I don't see it otherwise; I'm not sure why . . .' (Mum)

> 'It's helpful, I hadn't thought that she might be feeling alone in the family; I guess it's hard for her if Mum and Dad are making her go and then I'm mad at her, too.' (Sibling)
>
> 'Coming here and being told "make her go" went against everything we'd been told by other professionals, but it just made complete sense. Being given that message was like being given permission to do it.' (Mum & Dad)

Special Considerations

Gaming/computer addiction

Technology addiction in young people can, in itself, be a sign of dysfunctional patterns of relating within the family (Young, 2009). There are many similarities between the relational dynamics that underlie both school refusal and technology addiction, so it is not surprising these two problems often co-occur. If school refusal is complicated by computer addiction, I support parents to set firm limits around technology use and enforce them consistently, in addition to prompting parents to reflect on what unmet needs technology may be satisfying for the young person. Limit-setting with older children and adolescents can be more collaborative: parents might have a conversation with the young person about what limits they feel are reasonable and could adhere to; while parents have the 'final say,' setting limits in this way demonstrates respect for the young person's developing autonomy and is less likely to result in resentment (Allan & Power, 2011). Providing structure around technology use may have secondary benefits for the young person, such as improving sleep or daily routines, in addition to providing a greater sense of stability (Allan & Power, 2011).

It's been my experience that when young people become addicted to technology there is usually a good reason. I invite parents to consider *why* their young person might be so attracted by the lure of online gaming, social media, or the 'world-wide web': what unmet need is the young person trying to satisfy through their use of technology (Young, 2009)? For example, if the young person is seeking social connection through social media, the antidote is to support the development of peer relationships outside the virtual world. If the young person is seeking a sense of achievement or competence through online gaming, parents can look for ways to support the young person to have experiences of success in other ways, such as through sports or hobbies.

I have found that most parents find navigating the issue of technology addiction or overuse difficult to manage – technology is everywhere! Most students are now provided with laptops or iPads by school in order to complete homework and assessments. Parents are often reluctant to limit access to such devices for fear of impeding their child's learning. I encourage parents to determine what the minimum required access to technology is for their young person to meet their academic demands, in collaboration with the school if necessary. Additional technology time can be considered a reward like any other, around which parents determine appropriate limits.

Working with separated parents

When working with separated parents, unless there is very good reason not to (such as past or current family violence or abuse), I establish an expectation for parents to

attend all sessions together. I usually begin by acknowledging that for separated parents, the task of enforcing a return to school may be additionally challenging, however this does not excuse them from taking up this responsibility. I suggest that parents will be required to work together closely, which may be difficult if they no longer get along. Then I pose the question: 'Are you willing to set aside your differences to work together as parents to save your child?' This is an offer that is hard to refuse!

In practical terms, 'working together' often means the non-resident parent coming to the home where the child resides and acting with the resident parent to get the young person to school. I suggest that parents make time to discuss what's working and what is not, attend school meetings together, and anticipate how they will manage if the young person demands to live with the non-resident parent or 'runs away' to this parent's home when pressure to return to school is increased (in my experience, with adolescents this happens frequently).

Sometimes the relationship between the child and the resident parent has become so strained by the school refusal that a planned 'respite' stay with the non-resident parent can be helpful. This can allow the resident parent to focus more energy on repairing the relationship with the young person without the pressure of taking the 'lead role' in the return to school plan. Of course, the requirement for the young person to attend school still stands. Sometimes school refusal is the young person's way of expressing anger towards the resident parent and staying with the non-resident parent is enough to get the young person back to school. The task, then, becomes supporting the resident parent and young person to repair their relationship and use more adaptive means of communication. If this repair can be 'endorsed' and encouraged by the non-resident parent, all the better.

What if the young person threatens suicide?

I find this happens not infrequently. Statements of suicidal intent are always to be taken seriously, however I try and understand their *meaning* in reference to the age of the child. I think about suicidal statements made by an eight year old differently to those made by an older adolescent; the degree of actual risk, opportunity, and access to means is likely to be far greater in the case of the adolescent. In both cases, prompting the parents to consider suicidal statements as a communication of distress is helpful. It's helpful to prompt parents to think about how they can increase empathy and support for the young person (and, if necessary, increase monitoring to ensure safety) while remaining firm on the issue of school.

In the case of adolescents, suicidal statements are often made in response to the loss of control experienced by the young person as parents take charge of returning them to school (Bryce & Baird, 1986). The threat can be reframed not so much as a wish to die, but as a wish to remain in control and as a communication about the young person's anxiety about growing up (Bryce & Baird, 1986). It's important that parents are not scared into 'backing off' the issue of school; however, it may be necessary, for a time, to increase parental supervision in the context of a serious threat.

The situation is more complex if the young person has a history of suicidal or para-suicidal behaviour, or if there is a history of suicide in the family. Suicidal statements can act as triggers for past trauma for one or more family members (James & MacKinnon, 2012). It may be more difficult to have parents hold their ground, and they may require more support to do so. The ability for both clinician and family to

tolerate increased risk in the short term, in the interests of achieving longer term gains, is likely to be needed.

Practitioner Guidelines for Family Therapists

Here, I would like to summarise the therapeutic model and provide some guidelines for family therapists working with young people and families affected by school refusal.

Summary of the Model

- *A systemic formulation of the problem:* nature of the school refusal and a systemic formulation of family dynamics.
- *Raise awareness about the seriousness of the problem:* broaden the family's understanding of the current and future risks related to untreated school refusal.
- *Harness parental anxiety:* foster a productive level of anxiety in the parents in order to motivate them to act, being cautious not to induce so much anxiety they feel paralysed by the problem.
- *Debunk family 'myths' about the problem:* undermine medical or psychiatric explanations for school refusal behaviour and overt contrary understandings of the problem that exist within the family in order to develop a shared view of the problem and agenda for change.
- *Strengthening the parental subsystem and aligning the siblings:* support the parents to work together and assume parental responsibility for addressing the problem, while aligning the school-refusing youth with siblings who can provide empathy and support.
- *Recruit the young person as an ally:* look for age-appropriate ways to maximise the young person's autonomy and active participation in treatment while ensuring parents remain firmly in control until such time as school refusal is no longer a problem.
- *Broaden your understanding of the system:* work hard to develop a collaborative partnership between family, school, and treating team and attend to the relationships between different parts of the system as you would any other relationship in treatment.

'Top tips' for family therapists

The stronger your therapeutic alliance with the family, the harder you can push them

This might seem obvious, but I think it is a point worthy of explication. The more the family feel understood and supported, the more leverage you have as a therapist. The more pressure you place on parents to take charge of the problem, the more attention you should devote to nurturing your relationship with the family.

Respect parents' expertise, but don't leave them floundering

It's no use being so 'non-expert' that parents are left with no practical idea of what to do. Which is why I think it's OK to offer tentatively framed suggestions or ideas if the family express an interest in hearing them. Parents need to portray a sense of

confidence and strength to their young person in order to give the message they mean business; this is unlikely to be convincing unless parents actually possess some confidence they are up to the task. Furthermore, being too 'not knowing' can leave the family thinking you might know nothing – which will undermine their confidence in you.

Stuck? Go backwards in order to move forwards

If, after some time in treatment, parents are not able to take up parental responsibility for returning the young person to school in spite of an articulated desire and willingness to do so (and the therapy starts to have that dreaded 'stuck' feeling about it), it's reasonable to assume there may be something constraining one or both parents from changing. In this instance, a more detailed exploration of both parents' family of origin can reveal trans-generational issues that may be preventing the family from making progress.

Individual therapy isn't proscribed; it's just a matter of timing

If the young person is expressing a desire for individual therapy to assist them to manage their anxiety or work on any other aspect of their functioning, I think it's reasonable to support this – so long as it's in the interests of returning the young person to school as quickly as possible. Timing, however, is important. Engaging the young person in individual therapy at the outset of treatment – at the same time as you are attempting to harness parental anxiety and charge parents with the task of returning the young person to school – sends a contradictory message. Engaging the young person in individual therapy at this juncture undermines your structural intervention with the parents. Individual therapy can be considered once the parents are working hard to get their young person back to school.

. . . It's also a matter of who's asking

If parents are requesting individual therapy for the young person, I recommend being more cautious. It's often been my experience that parents requesting therapy for their young person when the young person is indifferent, ambivalent, or openly reluctant about this proposition, are often looking to the therapist to 'fix' their young person in the hope they (parents) will not have to go through the difficult process of overcoming the young person's resistance to returning to school. In this way, the request for individual therapy can be understood as a manifestation of avoidance on the part of parents.

Keep going

Try not to be discouraged by slow progress or even no progress. So long as you maintain a meaningful engagement with the family/school system, eventually something is bound to change. There's a lot to be said for having a little faith!

What if nothing works?

Sometimes, despite our best efforts, treatment does not work. While I think it is important to be persistent and to try one's best to support families (e.g., be willing to modify treatment if there is no change, seek supervision/consultation, increase the involvement of some professionals/agencies, reduce the involvement of others), I also believe it's equally important to acknowledge when things really aren't working. An

open discussion with the family about lack of progress and consideration of discharge can sometimes lead to a positive shift; other times it can allow families to voice their own concerns about lack of progress, or overt their ambivalence about treatment (concerns families often feel unable to raise) and lead to a 'good' discharge – one in which there is open acknowledgement that, for whatever reason, now is not the right time for the family to engage in treatment, however they will be welcomed back at any stage in future.

Conclusion

School refusal can be a difficult-to-treat problem with the ability to frustrate and challenge families and clinicians alike. Returning the young person to school as soon as possible is the priority (Fremont, 2003) and the active involvement of family is integral to treatment success (Carr, 2009). In this article I have outlined my guiding principles for intervention developed from my experiences of what works for families. Structural and post-Milan ideas inform my work, as do an ethic of collaboration and an inclusive understanding of what constitutes 'the system' (i.e., nuclear family, extended family, school, treating team, community supports). I believe that a strong alliance with the family, and working with as many parts of the system as possible to developing a shared understanding of the problem and shared agenda for change is the key to successful treatment.

Note

[1] Names and other identifying information have been changed in the interests of confidentiality.

References

Allan, D., & Power, L. (2011). Family therapy with adolescents: Key ideas and their application, in P. Rhodes & A. Wallis (Eds.), *A Practical Guide to Family Therapy: Structured Guidelines and Key Skills*. Melbourne: IP Communications.

Bernstein, G.A., & Borchardt, C.M. (1996). School refusal: Family constellation and family functioning. *Journal of Anxiety Disorders*, *10*(1), 1–19.

Bernstein, G.A., Warren, S.L., Massie, E.D., & Thuras, P.D. (1999). Family dimensions in anxious-depressed school refusers. *Journal of Anxiety Disorders*, *13*(5), 513–528.

Bryce, G., & Baird, D. (1986). Precipitating a crisis: Family therapy and adolescent school refusers. *Journal of Adolescence*, *9*, 199–213.

Carr, A. (2009). The effectiveness of family therapy and systemic interventions for child-focused problems. *Journal of Family Therapy*, *33*, 3–45.

Carter, B., & McGoldrick, M. (Eds.). (1999). *The Expanded Family Life Cycle: Individual, Family, and Social Perspectives*, 3rd edn. Boston, MA: Allyn & Unwin.

Egger, H.L., Costello, J., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. *Journal of the American Academy of Child and Adolescent Psychiatry*, *42* (7), 797–807.

Ek, H., & Eriksson, R. (2013). Psychological factors behind truancy, school phobia, and school refusal: A literature study. *Child and Family Behaviour Therapy*, *35*, 228–248.

Flakierska-Praquin, N., Lindstrom, M., & Gillberg, C. (1997). School phobia with separation anxiety disorder: A comparative 20- to 29-year follow-up study of 35 school refusers. *Comprehensive Psychiatry*, *38*, 17–22.

Fremont, W.P. (2003). School refusal in children and adolescents. *American Family Physician*, *68*(8), 1555–1560.

Ginsburg, G.S., Silverman, W.K., & Kurtines, W.K. (1995). Family involvement in treating children with phobic and anxiety disorders: A look ahead. *Clinical Psychology Review*, *15*(5), 457–473.

Hawkes, R. (1981). Paradox and a systems theory approach to a case of severe school phobia. *Australian Journal of Family Therapy*, *2*(2), 56–62.

Hawkes, R. (1982). Treatment of school refusal by strategic-based family therapy. *Australian Journal of Family Therapy*, *3*(3), 129–134.

Heyne, D., Sauter, F.M., Ollendick, T.H., Van Widenfelt, B.M., & Westenberg, P.M. (2014). Developmentally sensitive cognitive behavioural therapy for adolescent school refusal: Rationale and case illustration. *Clinical Child Family Psychology Review*, *17*, 191–215.

James, K., & MacKinnon, L. (2011). Establishing the parental hierarchy: An integration of Milan systemic and structural family therapy, in P. Rhodes & A. Wallis (Eds.), *A Practical Guide to Family Therapy: Structured Guidelines and Key Skills*. Melbourne: IP Communications.

James, K., & MacKinnon, L. (2012). Integrating a trauma lens into a family therapy framework: Ten principles for family therapists. *Australian and New Zealand Journal of Family Therapy*, Special Issue on Family Therapy and Trauma, *33*(3), 189–209.

Kearney, C.A. (2006). Dealing with school refusal behaviour: A primer for family physicians. *The Journal of Family Practice*, *55*(8), 685–692.

Kearney, C.A. (2008). School absenteeism and school refusal behaviour in youth: A contemporary review. *Clinical Psychology Review*, *28*, 451–471.

Kearney, C.A., & Silverman, W.K. (1995). Family environment of youngsters with school refusal behaviour: A synopsis with implications for assessment and treatment. *The American Journal of Family Therapy*, *23*(1), 59–66.

Lang, M. (1982). School refusal: An empirical study and system analysis. *Australian Journal of Family Therapy*, *3*(2), 93–107.

LeUnes, A., & Siemsglusz, S. (1977). Paraprofessional treatment of school phobia in a young adolescent girl. *Adolescence*, *12*(45), 115–121.

Levy, S.A., Creed, T.A., & Diamond, G.S. (2001). Improving relationship security for depressed adolescents, in P. Rhodes & A. Wallis (Eds.), *A Practical Guide to Family Therapy: Structured Guidelines and Key Skills*. Melbourne: IP Communications.

Menahem, S., & Cebon, A. (1984). Treat mother too – 'failed' psychotherapy of an adolescent with school refusal. *Child Psychiatry and Human Development*, *14*(3), 170–177.

Relph, A. (1984). Intervening in the school-family-clinic triangle. *Australian Journal of Family Therapy*, *5*(2), 117–124.

Rhodes, P. (2003). The Maudsley model of family therapy for children and adolescents with Anorexia Nervosa: Theory, clinical practice, and empirical support. *Australian and New Zealand Journal of Family Therapy*, *24*(4), 191–198.

Rhodes, P. (2008). Amplifying deviations in family interactions: Guidelines for trainees in post-Milan family therapy. *Australian and New Zealand Journal of Family Therapy*, *29*(1), 34–39.

Wallis, A., & Rhodes, P. (2011). Structured guidelines for the first session of post-Milan systemic therapy, in P. Rhodes & A. Wallis (Eds.), *A Practical Guide to Family Therapy: Structured Guidelines and Key Skills*. Melbourne: IP Communications.

Young, K. (2009). Understanding online gaming addiction and treatment issues for adolescents. *The American Journal of Family Therapy*, *37*, 355–372.