School Phobia With Separation Anxiety Disorder: A Comparative 20- to 29-Year Follow-up Study of 35 School Refusers

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The outcome of school phobia after age 30 years was studied with the hypothesis that school phobia cases would have persisting psychiatric problems, but would function better than nonschool refusal psychiatric patients. The subjects consisted of three groups. Thirty-five individuals treated for school phobia at ages 7 to 12 years were compared with age- and sex-matched nonschool refusal child psychiatric patients (n = 35) and a sample from the general population (n = 35). School phobia cases had had more psychiatric consultation, lived with their parents more often than the general population group, and had fewer children than both comparison groups. The nonschool refusal child psychiatric patients had poorer psychosocial adjustment and higher rates of criminal offenses. The implications of the findings are discussed.
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MOST FOLLOW-UP STUDIES of children with school refusal have been based on small samples and included relatively short follow-up periods. In addition, most studies have failed to include comparison groups (see Berg[1] for a recent review of the literature). Nursten[2] followed 23 girls with school refusal for 10 years from a mean age of 9 years, and included a comparison group. She found a greater rate of "phobic reactions" among the school refusers than in the normal group. Coolidge et al.[3] reported on outcome for a group of 47 school refusers 5 to 10 years after first contact; 13 (28%) had no mental health problems, 20 (43%) had some problems as regards self-support, and 14 (30%) had difficulties in most domains of mental/psychological well-being. Weiss and Burke[4] examined 16 school refusers 5 to 10 years after treatment. Approximately half showed good adjustment with regard to work and social relationships. There was a tendency for family patterns to be polarized, some probands broke off all relationships with their nuclear family, whereas others were completely dependent on the emotional and practical support of their parents and siblings. Berg and Jackson[5] reexamined 168 young teenagers 10 years after admission (at a mean age of 24 years). Thirty percent had been treated for psychiatric illness, 14% had applied for psychiatric care, and 5% had been admitted to psychiatric hospitals for treatment. Compared with data from local and national registers, school refusers appeared to show increased rates of psychiatric morbidity. Anxiety and depression were the main problems on follow-up. Children diagnosed with school refusal under age 14 years, and who were intellectually bright, had the best outcomes.

Eight years ago, the present investigators performed a follow-up study of all 35 individuals seen in a psychiatric university clinic because of school phobia at age 7 to 12 years. They were 24 to 29 years old at the time of this first follow-up, and the length of the follow-up period was 12 to 21 years. School attendance, social adjustment, and need for further psychiatric treatment in the school phobia group were compared with the same parameters in a group of school children from the general population, matched for age and sex. No major differences between the groups in respect of overall social adjustment were found. The school phobia cases had applied for psychiatric outpatient help in young adulthood significantly more often (usually for affective and anxiety symptoms), and they had fewer children of their own.[6] In this new follow-up study of the same school phobia cohort, follow-up intervals have been increased to 20 to 29 years, and a non-school refusal child psychiatric patient group and a general population sample have been included for comparison. All subjects were older than 30 years at the time of the new follow-up study.

Our hypotheses were that (1) the school phobia cases would continue to show more signs of psychiatric disorder than any of the two comparison groups; (2) the school phobia cases (due to their socially avoidant behavior) may have fewer social contacts and, hence, be living with their parents and have fewer children of their own; and (3) the non-school refusal cases would show poor adjust-

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ment psychosocially as compared with the other two groups. We use the term school phobia to make clear that we do not include all school refusers in our proband group. We are aware that most current researchers would have used "school refusal" where we refer to "school phobia."

METHODS

School Phobia

Thirty-five children with school phobia (16 boys, 19 girls) were selected from all 7- to 12-year-old patients who had been treated at the University Clinic of Child and Adolescent Psychiatry in Göteborg, Sweden from 1961 to 1970. Fourteen of the patients had been treated as inpatients and the remaining 21 had received outpatient treatment only. Five children had applied for child psychiatric help for other problems before school refusal prompted referral. In the 1960s, Swedish children with school refusal, unlike other child psychiatric patients, were often admitted for intense inpatient therapy.

The 500 case records of all child psychiatric clinic patients were scrutinized conjointly by the first two authors (N.F-P. and M.L.), and cases meeting the following criteria were included for further examination: (1) Prolonged or recurrent refusal to go to and absence from school; (2) purported physical symptoms or purported hostility from teachers or peers in school; (3) normal intelligence (IQ > 70); (4) no indications of major social or family dysfunction (because we wanted to minimize the risk that truants rather than children with school phobia would be included in the sample; it is well-known that truancy is associated with family and social dysfunction and that such dysfunction sometimes precludes the elicitation of adequate information for a valid diagnosis to be made); and (5) no registered delinquency.

The selected cases were then reanalyzed with a view to assigning diagnoses according to the DSM-III.[7] All 35 cases met the criteria for separation anxiety disorder. We believe that this accurately reflects the level of comorbidity between school phobia—as defined in this study—and separation anxiety disorder because no other cases with clear school refusal were found among the 500 case records scrutinized. The rate of separation anxiety disorder among the remaining 465 cases was not systematically examined, meaning that we do not know how specific the association of school phobia with separation anxiety disorder is. It is conceivable that the strength of the association of school phobia and separation anxiety may have been overestimated in our sample because, at the time of treatment in childhood (in the 1960s), prevailing theoretical attitudes in Swedish child psychiatry tended to favor a link between these two types of problems. This means that, in the medical psychiatric records, school refusal may have been mentioned more often in children showing separation anxiety and vice versa.

Forty-nine percent of the children had working-class parents (as determined by father's occupation). Two children did not live with both parents, and 33 were raised in unbroken families. The school refusers constituted 7% of the total population of child psychiatric patients. This figure accords well with those obtained by Chazan,[8] Kahn and Nursten,[9] King and Tonge,[10] and Smith.[11]

Other Child Psychiatric Patients

Thirty-five subjects were selected from psychiatric medical records by pair-wise matching for age (±1 year), sex, and period of treatment (1961 to 1970). The age match led to an almost perfect match also in respect of school grade. The records from which this group was recruited comprised all non-school refusal children treated in the in- or outpatient child and adolescent psychiatric services in Göteborg.

Case records were scrutinized separately by the first two authors (N.F-P. and M.L.) and, on the basis of this information, cases were rediagnosed according to the DSM-III. Selection of cases for inclusion was not affected in this process. Blind agreement was achieved in 86% of the cases (30 of 35). A conjoint diagnosis was agreed on in 14% (5 of 35) of the cases in this group for whom there had not been initial agreement. In a few instances, diagnoses that are not in the DSM-III were made. The diagnoses are shown in Table 1. Thirty-four subjects in this group had been treated as outpatients and one as an inpatient. An additional two cases were treated as inpatients after 12 years of age. Twenty-eight percent of these patients had been placed in some kind of institution (treatment home, psychiatric clinic, or custody of social services) before age 18 years. Sixty-nine percent had working class parents (as determined by father's occupation). Only 57% of the children grew up in unbroken families.

Table 1. Main Childhood Diagnosis

Group/Diagnosis	School Phobia (n = 35)	Other Child Psychiatric Patients (n = 35)	Normal (n = 35)
Never consulted child and adolescent psychiatrist	0	0	30
Conduct or oppositional disorder	0	11	2
ADD	0	1	0
Dysthymia	0	3	0
Anxiety disorders	35	6	2
Overanxious disorder	(0)	(4)	(2)
Generalized anxiety disorder	(0)	(1)	(0)
Separation anxiety disorder	(35)	(1)	(0)
OCD	0	1	0
Tics	0	1	0
Reading disorder	0	1	0
Encopresis	0	2	0
Enuresis	0	2	0
Atypical stereotyped movement disorder	0	2	0
Adjustment disorder	0	2	0
Nightmare disorder*	0	1	0
Grief reaction*	0	2	0
Battered child syndrome*	0	0	1

NOTE. DSM-III criteria except where indicated.

Abbreviations: ADD, attention deficit disorder; OCD, obsessive-compulsive disorder.

*Not in DSM-III.

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