Brit. J. Psychiat. (1981), **141**, 208–210

Comments

WHEN TRUANTS AND SCHOOL REFUSERS GROW UP

Truancy is the term commonly used to describe unjustifiable absence from school. Persistent truancy occurs in approximately 1 per cent of primary school children. It increases considerably over the secondary school years to affect about 10 per cent of 15-year-olds. It is often associated with evidence of other antisocial activity. Educational attainment is inclined to be low. And children who truant often come from disadvantaged homes (Fogelman *et al*, 1980). Truancy in cases referred to child psychiatrists is usually just one manifestation of a conduct disorder characterized by a whole variety of antisocial behaviour (Hersov, 1960).

Many of the large number of truants in the year or two before the end of compulsory schooling at age 16 are probably demonstrating their disenchantment with the educational system, rather than expressing severe individual psychopathology, since their main disadvantage when they start work seems to reflect lack of academic qualifications rather that anything else (Gray *et al*, 1980). On the other hand severe truancy in primary school and in the first few years of secondary school appears to have implications for adult life. This has so far only been established in boys. No comparable investigations up to now have been undertaken looking at the long-term outcome of truancy in girls. Longitudinal studies carried out in Britain and the United States involving adult males have shown that a whole range of antisocial activities at that stage of life are predicted by childhood antisocial behaviour in general, (West and Farrington, 1977; Robins, 1978) and truancy, in particular (Farrington, 1980; Robins and Ratcliffe, 1980). The adult deviant behaviour includes criminality, marital difficulties, violence, excessive drinking, employment problems, drug abuse and gambling.

Although many boys who stay away from school persistently without an acceptable excuse grow up without showing deviant behaviour in adult life, a significant proportion of them, particularly those who have associated childhood antisocial behaviour of other kinds, do appear to remain prone to antisocial activity when they are adult. Truancy would seem to be a useful indication of vulnerability to later problems and its effective 'treatment' could help to reduce these. So far only judicial procedures have been found to produce a substantial improvement in severe truancy (Berg *et al*, 1978).

School refusal, alternatively called school phobia, is much less prevalent than truancy (Marks, 1970a) although very familiar to child and adolescent psychiatrists (Agras *et al*, 1969). In Britain it most commonly affects young teenagers and is a manifestation of emotional disturbances. Youngsters with this problem are unwilling to leave home and go to school. They usually show other evidence of a neurotic disorder (Berg, 1980) whereas antisocial behaviour is conspicuous by its absence. In fact, truancy and school refusal exemplify the distinction between antisocial and emotional disorders in the classification of psychiatric conditions affecting children (Rutter, 1965). It is important to keep this categorization in mind when considering the long-term outcome of school refusal.

Young people suffering from school refusal often have similar problems to patients with agoraphobia. In both, there is a neurotic disturbance, they tend to stay home excessively and often require the support of the family or a close friend to go into certain situations (Berg, 1980). As with agoraphobia (Hallam, 1978), it can be argued that school refusal is only a variant of neurotic disturbance at this stage of life.

About 15 per cent of adults with agoraphobia begin to suffer from that condition during their school years (Marks, 1970b). Two retrospective investigations, one involving 843 women (Berg *et al*, 1974) and the other 240 men and women (Tyrer and Tyrer, 1974) suffering from either agoraphobia or other kinds of neurotic disturbance, showed that these individuals had suffered from school refusal when they were young to a far greater extent than would have been expected.

Follow-up studies of young people with neurotic disorders and school refusal are few in number and often unsatisfactory. One study was concerned with the review of 500 children who had been referred to a child guidance service in the 1920s (Robins, 1966). There was no evidence of any relationship between neurotic disturbance in childhood and adult life. These were probably atypical cases by present day standards and all were under 14 years of age when first treated. On the other hand, a longitudinal study of 732 young people carried out in Manhattan showed that neurotic features persisted between ages 15 and 20 (Gersten *et al*, 1976). A review of 16 school phobic

https://doi.org/10.1192/bjp.141.2.208 Published online by Cambridge University Press

adolescents six years after receiving inpatient treatment showed that as young adults four had severe phobic states, three suffered from phobic symptoms and three had other neurotic difficulties (Warren, 1960). There are two follow-up studies limited in value because of poor design. One was concerned with 49 school phobic children of primary school age who were reviewed after 10 (Coolidge *et al*, 1964) and again after 21 years (Waller and Eisenberg, 1980), and the other involved 24 school refusers under 13 years of age and 18 other neurotic conditions, reviewed as young adults (Waldron, 1976). Both indicated persisting neurotic problems including agoraphobic difficulties to a greater extent than would be expected.

One hundred school refusers were followed up on average three years after discharge from hospital when they were in their late teens (Berg *et al*, 1976). A third of them had persisting symptoms of neurotic disturbance and continuing social impairment. Five girls and a boy had developed severe agoraphobic symptoms. A recent (unpublished) follow-up study by the writer has been carried out and so far information is available on the 10 year outcome of 63 school phobic individuals. It was found that about a fifth of cases had suffered from continuing symptoms and severe social impairment for over three quarters of the 10 year period. About a third had received further treatment for psychiatric disturbance mostly neurotic disorders and depression. Three girls and three boys had persistent phobic states in this group, and five others had some agoraphobic symptoms.

Agoraphobic symptoms occur more commonly in women than men (Hallam, 1978). Although school refusal affects boys and girls equally there are some features which occur more frequently in girls. Studies of dependency have shown that girls rather than boys with school refusal have difficulty travelling on their own away from home (Berg, 1974). In the study of a large group of agoraphobic women already referred to, it was found that their daughters rather than their sons in family sizes of two were particularly likely to get school refusal (Berg, 1976). Girls with school refusal have shown a better response than boys to treatment directed towards improving social skills (Berg and Fielding, 1978). In conclusion, little work has so far been done on the possible connections between neurotic disorders (including school refusal) affecting young people and affective or neurotic disorders (including agoraphobia) occurring in adult life, but the present evidence suggests that there are indications of a relationship.

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https://doi.org/10.1192/bjp.141.2.208 Published online by Cambridge University Press