School Refusal in Children and Adolescents

WANDA P. FREMONT, M.D., State University of New York Upstate Medical University, Syracuse, New York

School refusal is a problem that is stressful for children, families, and school personnel. Failing to attend school has significant short- and long-term effects on children's social, emotional, and educational development. School refusal often is associated with comorbid psychiatric disorders such as anxiety and depression. It is important to identify problems early and provide appropriate interventions to prevent further difficulties. Assessment and management of school refusal require a collaborative approach that includes the family physician, school staff, parents, and a mental health professional. Because children often present with physical symptoms, evaluation by a physician is important to rule out any underlying medical problems. Treatments include educational-support therapy, cognitive behavior therapy, parent-teacher interventions, and pharmacotherapy. Family physicians may provide psychoeducational support for the child and parents, monitor medications, and help with referral to more intensive psychotherapy. (Am Fam Physician 2003;68:1555-60,1563-4. Copyright© 2003 American Academy of Family Physicians.)

A patient information handout on school refusal, written by the author of this article, is provided on page 1563.

A PDF version of this document is available. Download PDF now (7 pages /81 KB). More information on using PDF files.

School refusal is a serious emotional problem that is associated with significant short- and long-term sequelae. Fear of going to school was first termed school phobia in 1941. [1] An alternative term, school refusal, was used in Great Britain to define similar problems in children who did not attend school because of emotional distress. [2] Children with school refusal differ in important ways from children who are truant *(Table 1),* although the behaviors are not mutually exclusive.

TABLE 1
Criteria for Differential Diagnosis of School Refusal and Truancy

School refusal	*Truancy*
Severe emotional distress about attending school; may include anxiety,	Lack of excessive anxiety or fear about attending school.

temper tantrums, depression, or somatic symptoms.	
Parents are aware of absence; child often tries to persuade parents to allow him or her to stay home.	Child often attempts to conceal absence from parents.
Absence of significant antisocial behaviors such as juvenile delinquency.	Frequent antisocial behavior, including delinquent and disruptive acts (e.g., lying, stealing), often in the company of antisocial peers.
During school hours, child usually stays home because it is considered a safe and secure environment.	During school hours, child frequently does not stay home.
Child expresses willingness to do schoolwork and complies with completing work at home.	Lack of interest in schoolwork and unwillingness to conform to academic and behavior expectations.

Epidemiology

Approximately 1 to 5 percent of all school-aged children have school refusal. [3] The rate is similar between boys and girls. [4,5] Although school refusal occurs at all ages, it is more common in children five, six, 10, and 11 years of age. [6] No socioeconomic differences have been noted. [7]

Clinical Features

The onset of school refusal symptoms usually is gradual. Symptoms may begin after a holiday or illness. Some children have trouble going back to school after weekends or vacations. Stressful events at home or school, or with peers may cause school refusal. Some children leave home in the morning and develop difficulties as they get closer to school, then are unable to proceed. Other children refuse to make any effort to go to school.

Presenting symptoms include fearfulness, panic symptoms, crying episodes, temper tantrums, threats of self-harm, and somatic symptoms [8] that present in the morning and improve if the child is allowed to stay home *(Table 2)* . The longer the child stays out of school, the more difficult it is to return. [9]

TABLE 2
Somatic Symptoms in Children with School Refusal

Autonomic	Gastrointestinal	Muscular
Dizziness	Abdominal pain	Back pain
Diaphoresis	Nausea	Joint pain
Headaches	Vomiting	
Shakiness/trembling	Diarrhea	
Palpitations		
Chest pains		

TABLE 3
Long-Term Sequelae in Children with School Refusal

Outcome	*Prevalence*
Interrupted compulsory school	18%
Did not complete high school	45%
Adult psychiatric outpatient care	43%
Adult psychiatric inpatient care	6%
Criminal offense	6%
Still living with parents after 20-year follow-up	14%
Married at 20-year follow-up	41%
Number of children at 20-year follow-up	
None	59%

	One or more 41%
	Information from references 11 and 12.

Short-term sequelae include poor academic performance, family difficulties, and problems with peer relationships. [10] Long-term consequences may include academic underachievement, employment difficulties, and increased risk for psychiatric illness *(Table 3).* [11,12]

Associated Psychiatric Disorders

Children with school refusal usually present with anxiety symptoms, and adolescents have symptoms associated with anxiety and mood disorders.

School refusal is not a formal psychiatric diagnosis. However, children with school refusal may suffer from significant emotional distress, especially anxiety and depression. [13]

Children with school refusal usually present with anxiety symptoms, and adolescents have symptoms associated with anxiety and mood disorders. [14] The most common comorbid psychiatric disorders include separation anxiety, social phobia, simple phobia, panic disorder, post-traumatic stress disorder, major depressive disorder, dysthymia, and adjustment disorder. *(Table 4).* [7,13,15]

School refusal should be considered a heterogeneous and multicausal syndrome. School avoidance may serve different functions depending on the individual child. [16] These may include avoidance of specific fears provoked by the school environment (e.g., test-taking situations, bathrooms, cafeterias, teachers), escape from aversive social situations (e.g., problems with classmates or teachers), separation anxiety, or attention-seeking behaviors (e.g., somatic complaints, crying spells) that worsen over time if the child is allowed to stay home.

Assessment of a child with school refusal should include a complete medical history and physical examination, history of the onset and development of school refusal symptoms, associated stressors, school

history, peer relationships, family functioning, psychiatric history, substance abuse history, and a mental status examination.

Family Functioning

Problems with family functioning contribute to school refusal in children; however, few studies have systematically evaluated and measured these problems. Parents of children with school avoidance and separation anxiety have an increased rate of panic disorder and agoraphobia. [17]

Dysfunctional family interactions that correlate with school refusal include overdependency, detachment with little interaction among family members, isolation with little interaction outside the family unit, and a high degree of conflict. [18] Communication problems within families, problems in role performance (especially in single-parent families), and problems with family members' rigidity and cohesiveness also have been identified. [19,20]

Assessment

Because children with school refusal present with a wide variety of clinical symptoms, a comprehensive evaluation is recommended. School refusal is a complex problem, and physicians must allocate a sufficient amount of time to the patient to make an accurate assessment and recommend effective interventions. Often, more than one appointment is needed.

TABLE 4
TitlePsychiatric Disorders in Children with School Refusal

Anxiety disorders	Disruptive behavior disorders
Separation anxiety	Oppositional defiant disorder
Anxiety disorder, NOS	Conduct disorder
Generalized anxiety disorder	Attention-deficit/hyperactivity disorder
Social phobia	Disruptive behavior disorder, NOS
Simple	Other disorders
	Adjustment

TABLE 5
Assessment of School Refusal

Complete medical history and physical

Clinical interview with child and parents

History of onset and development of symptoms

Associated stressors

phobia
Panic disorder
Panic disorder with agoraphobia
Post-traumatic stress disorder
Agoraphobia

Mood disorders
Major depression
Dysthymia

disorder (with depressed mood or anxiety)
Learning disorder
Substance abuse
Other

NOS = not otherwise specified.

Adapted with permission from McShane G, Walter G, Rey JM. Characteristics of adolescents with school refusal. Aust N Z J Psychiatry 2001;35:824, with information from references 7 and 15.

School history

Family psychiatric history

Mental status examination including evaluation for psychiatric problems and substance abuse

Assessment of family dynamics and functioning

Collaboration with school staff

Review of school attendance records, report cards, and psychoeducational evaluations

Psychologic assessment tools (e.g., clinical rating scales, self-report scales, parent and teacher report instruments)

The evaluation should include interviews with the family and individual interviews with the child and parents. Assessment should include a complete medical history and physical examination, history of the onset and development of school refusal symptoms, associated stressors, school history, peer relationships, family functioning, psychiatric history, substance abuse history, and a mental status examination. Identification of specific factors responsible for school avoidance behaviors is important. Collaboration with school staff in regards to assessment and treatment is necessary for successful management *(Table 5)* . School personnel can provide additional information to aid in assessment, including review of attendance records, report cards, and psychoeducational evaluations.

Several psychologic assessment tools (e.g., teacher and parent rating scales, self-report measures, clinician rating scales) have been developed to provide additional information about the child's general functioning at home and at school. These tools may be used by a physician, but because of time constraints, a school psychologist or mental health counselor should administer these scales whenever possible. Generalized scales (e.g., Child Behavior Checklist, [21] Teacher's Report Form [22]) identify areas of difficulties. Specific rating scales assess for symptoms and severity of psychiatric problems, including anxiety and depression. Although these scales are used frequently in children with school refusal, their clinical usefulness in developing effective treatment strategies has not been demonstrated.

The School Refusal Assessment Scale includes a child, parent, and teacher form and is reported to have a high reliability and validity.

More specific assessment scales to measure symptoms of school refusal have been developed recently. They provide functional and symptomatic assessment of refusal behaviors and therefore provide more valuable information. The School Refusal Assessment Scale *(Table 6, online)* [23] includes a child, parent, and teacher form and examines school refusal in correlation to negative and positive reinforcers. This scale has been reported to have high reliability and validity. [23,24]

TABLE 6
Items from the School Refusal Assessment Scale-Revised

Items from child version

How often do you have bad feelings about going to school because you are afraid of something related to school (e.g., tests, school bus, teacher, fire alarm)? (1)

How often do you stay away from school because it is hard to speak with the other kids at school? (2)

How often do you feel you would rather be with your parents than go to school? (3)

When you are not in school during the week (Monday to Friday), how often do you leave the house and do something fun? (4)

How often do you stay away from school because you feel sad or depressed if you go?

(1)

How often do you stay away from school because you feel embarrassed in front of other people at school? (2)

How often do you think about your parents or family when you are in school? (3)

When you are not in school during the week (Monday to Friday), how often do you talk to or see other people (other than your family)? (4)

How often do you feel worse at school (e.g., scared, nervous, sad) compared with how you feel at home with friends? (1)

How often do you stay away from school because you do not have many friends there? (2)

How much would you rather be with your family than go to school? (3)

When you are not in school during the week (Monday to Friday), how much do you enjoy doing different things (e.g., being with friends, going places)? (4)

How often do you have bad feelings about school (e.g., scared, nervous, sad) when you think about school on Saturday and Sunday? (1)

How often do you stay away from places in school (e.g., hallways, places where certain groups of people are) where you would have to talk to someone? (2)

How much would you rather be taught by your parents at home than by your teacher at school? (3)

How often do you refuse to go to school because you want to have fun outside of school? (4)

If you had fewer bad feelings (e.g., scared, nervous, sad) about school, would it be easier for you to go to school? (1)

If it were easier for you to make new friends, would it be easier for you to go to school? (2)

Would it be easier for you to go to school if your parents went with you? (3)

Would it be easier for you to go to school if you could do more things you like to do after school hours (e.g., being with friends)? (4)

How much more do you have bad feelings about school (e.g., scared, nervous, sad) compared with other kids your age? (1)

How often do you stay away from people in school compared with other kids your age? (2)

Would you like to be home with your parents more than other kids your age would? (3)

Would you rather be doing fun things outside of school more than most kids your age? (4)

Items from parent version

How often does your child have bad feelings about going to school because he/she is afraid of something related to school (e.g., tests, school bus, teacher, fire alarm)? (1)

How often does your child stay away from school because it is hard for him/her to speak with the other kids at school? (2)

How often does your child feel he/she would rather be with you or your spouse than go to school? (3)

When your child is not in school during the week (Monday to Friday), how often does he/she leave the house and do something fun? (4)

How often does your child stay away from school because he/she will feel sad or depressed if he/she goes? (1)

How often does your child stay away from school because he/she feels embarrassed in front of other people at school? (2)

When your child is in school, how often does he/she think about you or your spouse or family? (3)

When your child is not in school during the week (Monday to Friday), how often does he/she talk to or see other people (other than his/her family)? (4)

How often does your child feel worse at school (e.g., scared, nervous, sad) compared with how he/she feels at home with friends? (1)

How often does your child stay away from school because he/she does not have many friends there? (2)

How much would your child rather be with his/her family than go to school? (3)

When your child is not in school during the week (Monday to Friday), how much does he/she enjoy doing different things (e.g., being with friends, going places)? (4)

How often does your child have bad feelings about school (e.g., scared, nervous, sad) when he/she thinks about school on Saturday and Sunday? (1)

How often does your child stay away from places in school (e.g. hallways, places where certain groups of people are) where he/she would have to talk to someone? (2)

How much would your child rather be taught by you or your spouse at home than by his/her teacher at school? (3)

How often does your child refuse to go to school because he/she wants to have fun outside of school? (4)

If your child had fewer bad feelings (e.g., scared, nervous, sad) about school, would it be easier for him/her to go to school? (1)

If it were easier for your child to make new friends, would it be easier for him/her to go to school? (2)

Would it be easier for your child to go to school if you or your spouse went with him/her? (3)

Would it be easier for your child to go to school if he/she could do more things he/she likes to do after school hours (e.g., being with friends)? (4)

How much more does your child have bad feelings about school (e.g., scared, nervous, sad) compared with other kids his/her age? (1)

How often does your child stay away from people in school compared with other kids his/her age? (2)

Would your child like to be home with you or your spouse more than other kids his/her age would? (3)

Would your child rather be doing fun things outside of school more than most kids his/her age? (4)

---

1 = avoidance of stimuli that provoke negative affectivity; 2 = escape from aversive

social or evaluative situations; 3 = pursuit of attention; 4 = pursuit of tangible reinforcement.

Adapted with permission from Kearney CA. Identifying the function of school refusal behavior: a revision of the School Refusal Assessment Scale. J Psychopathol Behav Assess 2002;24:235-45.

Treatment

The primary treatment goal for children with school refusal is early return to school. Physicians should avoid writing excuses for children to stay out of school unless a medical condition makes it necessary for them to stay home. Treatment also should address comorbid psychiatric problems, family dysfunction, and other contributing problems. Because children who refuse to go to school often present with physical symptoms, the physician may need to explain that the problem is a manifestation of psychologic distress rather than a sign of illness. A multimodal, collaborative team approach should include the physician, child, parents, school staff, and mental health professional.

Treatment options include education and consultation, behavior strategies, family interventions, and possibly pharmacotherapy. Factors that have been proved effective for treatment improvement are parental involvement and exposure to school. [25,26] [Reference 25--Evidence level B, uncontrolled trial] However, few controlled studies have evaluated the efficacy of most treatments. Treatment strategies must take into account the severity of symptoms, comorbid diagnosis, family dysfunction, and parental psychopathology.

A range of empirically supported exposure-based treatment options are available in the management of school refusal. When a child is younger and displays minimal symptoms of fear, anxiety, and depression, working directly with parents and school personnel without direct intervention with the child may be sufficient treatment. If the child's difficulties include prolonged school absence, comorbid psychiatric diagnosis, and deficits in social skills, child therapy with parental and school staff involvement is indicated.

BEHAVIOR INTERVENTIONS

Behavior approaches for the treatment of school refusal are primarily exposure-based treatments. [27] [Evidence level B, lower quality randomized controlled trial (RCT)] Studies have shown that exposure to feared objects or situations reduces fear and increases exposure attempts in adults. [28] These techniques have been used to treat children with phobias and school refusal. Behavior techniques focus on a child's behaviors rather than intrapsychic conflict and emphasize treatment in the context of the family and school.

Behavior treatments include systematic desensitization (i.e., graded exposure to the school environment), relaxation training, emotive imagery, contingency management, and social skills training. Cognitive behavior therapy is a highly structured approach that includes specific instructions for children to help gradually increase their exposure to the school environment. In cognitive behavior therapy, children are encouraged to confront their fears and are taught how to modify negative thoughts.

EDUCATIONAL-SUPPORT THERAPY

Traditional educational and supportive therapy has been shown to be as effective as behavior therapy for the management of school refusal. [29] [Evidence level B, lower quality RCT] Educational-support therapy is a combination of informational presentations and supportive psychotherapy. Children are encouraged to talk about their fears and identify differences between fear, anxiety, and phobias. Children are given information to help them overcome their fears about attending school. They are given written assignments that are discussed at follow-up sessions. Children keep a daily diary to describe their fears, thoughts, coping strategies, and feelings associated with their fears. Unlike cognitive behavior therapy, children do not receive specific instructions on how to confront their fears, nor do they receive positive reinforcement for school attendance.

Child therapy involves individual sessions that incorporate relaxation training (to help the child when he or she approaches the school grounds or is questioned by peers), cognitive therapy (to reduce anxiety-provoking thoughts and provide coping statements), social skills training (to improve social competence and interactions with peers), and desensitization (e.g., graded in vivo exposure, emotive imagery, systematic desensitization).

PARENT-TEACHER INTERVENTIONS

Parental involvement and caregiver training are critical factors in enhancing the effectiveness of behavior treatment. Behavior interventions appear to be equally effective with or without direct child involvement. [25] [Evidence level B, lower quality RCT] School attendance and child adjustment at post-treatment follow-up are the same for children who are treated with child therapy alone and for children whose parents and teachers are involved in treatment.

Parent-teacher interventions include clinical sessions with parents and consultation with school personnel. Parents are given behavior-management strategies such as escorting the child to school, providing positive reinforcement for school attendance, and decreasing positive reinforcement for staying home (e.g., watching television while home from school). Parents also benefit from cognitive training to help reduce their own anxiety and understand their role in helping their children make effective changes. School consultation involves specific recommendations to school staff to prepare for the child's return, use of positive reinforcement, and academic, social, and emotional accommodations.

PHARMACOLOGIC TREATMENT

Pharmacologic treatment of school refusal should be used in conjunction with behavioral or psychotherapeutic interventions, not as the sole intervention. Interventions that help children develop skills to master their difficulties prevent a recurrence of symptoms after medication is discontinued.

Very few double-blind, placebo-controlled studies have evaluated the use of psychopharmacologic agents in the treatment of school refusal, although several controlled studies are in progress. Problems with sample sizes, differences in comorbidity patterns, lack of control of adjunctive therapies, and differences in medication dosages have resulted in inconclusive data in trials of pharmacologic agents in the treatment of school refusal. [30,31] Earlier studies of tricyclic antidepressants failed to show a replicable pattern of efficacy.

Selective serotonin reuptake inhibitors (SSRIs) have replaced tricyclic antidepressants as the first-line pharmacologic treatment for anxiety disorders in children and adolescents. Although there are few controlled, double-blind studies of SSRI use in children, preliminary research suggests that SSRIs are effective and safe in the treatment of childhood anxiety disorders and depression. [32,33] [Reference 32--Evidence level B, nonrandomized study] Fluvoxamine (Luvox) and sertraline (Zoloft) have been approved for the treatment of obsessive compulsive disorder in children. SSRIs are being used clinically with more frequency to treat children with school refusal.

Benzodiazepines have been used on a short-term basis for children with severe school refusal. A benzodiazepine initially may be prescribed with an SSRI to target acute symptoms of anxiety; once the SSRI has had time to produce beneficial effects, the benzodiazepine should be discontinued. Side effects of benzodiazepines include sedation, irritability, behavior disinhibition, and cognitive impairment. Because of the side effects and risk of dependence, benzodiazepines should be used for only a few weeks. [34]

The author thanks John Smucny, M.D., for assistance in preparing the manuscript.

The author indicates that she does not have any conflicts of interest. Sources of funding: none reported.

The Author

WANDA P. FREMONT, M.D., is director of the child and adolescent psychiatry residency program and assistant professor in the Department of Psychiatry, State University of New York (SUNY) Upstate Medical University, Syracuse, where she received her medical degree. Dr. Fremont also teaches in the family medicine residency program at SUNY Upstate Medical University.

Address correspondence to Wanda P. Fremont, M.D., SUNY Upstate Medical University, Division of Child and Adolescent Psychiatry, 750 E. Adams St., Syracuse, NY 13210 (e-mail: fremontw@upstate.edu). Reprints are not available from the author.

REFERENCES

1. Johnson AM, Falstein EI, Szurek SA, Svendsen M. School phobia. Am J Orthopsychiatry 1941;11:702-11.
2. Hersov LA. Refusal to go to school. J Child Psychol Psychiatry 1960;1:137-45.
3. Burke AE, Silverman WK. The prescriptive treatment of school refusal. Clin Psychol Rev 1987;7:353-62.
4. Granell de Aldaz E, Vivas E, Gelfand DM, Feldman L. Estimating the prevalence of school refusal and school-related fears. A Venezuelan sample. J Nerv Ment Dis 1984;172:722-9.
5. Heyne D, King NJ, Tonge BJ, Cooper H. School refusal: epidemiology and management. Paediatr Drugs 2001;3:719-32.
6. Ollendick TH, Mayer JA. School phobia. In: Turner SM, ed. Behavioral theories and treatment of anxiety. New York: Plenum Press, 1984:367-406.
7. Last CG, Strauss CC. School refusal in anxiety-disordered children and adolescents. J Am Acad Child Adolesc Psychiatry 1990;29:31-5.
8. Bernstein GA, Massie ED, Thuras PD, Perwien AR, Borchardt CM, Crosby RD. Somatic symptoms in anxious-depressed school refusers. J Am Acad Child Adolesc Psychiatry 1997;36:661-8.
9. Kennedy WA. School phobia: rapid treatment of fifty cases. J Abnorm Psychol 1965;70:285-9.
10. Hersov L. School refusal. Br Med J 1972;3:102-4.
11. Bernstein GA, Hektner JM, Borchardt CM, McMillan MH. Treatment of school refusal: one-year follow-up. J Am Acad Child Adolesc Psychiatry 2001;40:206-13.
12. Flakierska-Praquin N, Lindstrom M, Gillberg C. School phobia with separation anxiety disorder: a comparative 20- to 29-year follow-up study of 35 school refusers. Compr Psychiatry 1997;38:17-22.
13. McShane G, Walter G, Rey JM. Characteristics of adolescents with school refusal. Aust N Z J Psychiatry 2001;35:822-6.
14. Buitelaar JK, van Andel H, Duyx JH, van Strien DC. Depressive and anxiety disorders in adolescence: a follow-up study of adolescents with school refusal. Acta Paedopsychiatr 1994;56:249-53.
15. Bernstein GA. Comorbidity and severity of anxiety and depressive disorders in a clinic sample. J Am Acad Child Adolesc Psychiatry 1991;30:43-50.
16. Kearney CA, Silverman WK. A preliminary analysis of a functional model of assessment and treatment for school refusal behavior. Behav Modif 1990;14:340-66.
17. Martin C, Cabrol S, Bouvard MP, Lepine JP, Mouren-Simeoni MC. Anxiety and depressive disorders in fathers and mothers of anxious school-refusing children. J Am Acad Child Adolesc Psychiatry 1999;38:916-22.

18. Kearney CA, Silverman WK. Family environment of youngsters with school refusal behavior: a synopsis with implications for assessment and treatment. Am J Fam Ther 1995;23:59-72.
19. Bernstein GA, Borchardt CM. School refusal: family constellation and family functioning. J Anxiety Disord 1996;10:1-19.
20. Bernstein GA, Warren SL, Massie ED, Thuras PD. Family dimensions in anxious-depressed school refusers. J Anxiety Disord 1999;13:513-28.
21. Achenbach TM. Child Behavioral Checklist (CBCL). In: Achenbach TM. Manual for the Child Behavior Checklist/4-18 and 1991 Profile. Burlington, Vt.: University of Vermont, Department of Psychiatry, 1991.
22. Achenbach TM. Teacher's report form. In: Achenbach TM. Manual for the Teacher's Report Form and 1991 profile. Burlington, Vt.: University of Vermont, Department of Psychiatry, 1991.
23. Kearney CA. Identifying the function of school refusal behavior: a revision of the School Refusal Assessment Scale. J Psychopathol Behav Assess 2002;24:235-45.
24. Kearney CA, Silverman WK. Measuring the function of school refusal behavior: the School Assessment Scale. J Clin Child Psychol 1993;22:85-96.
25. Heyne D, King NJ, Tonge BJ, Rollings S, Young D, Pritchard M, et al. Evaluation of child therapy and caregiver training in the treatment of school refusal. J Am Acad Child Adolesc Psychiatry 2002; 41:687-695.
26. Blagg NR, Yule W. The behavioural treatment of school refusal: a comparative study. Behav Res Ther 1984;22:119-127.
27. King NJ, Tonge BJ, Heyne D, Pritchard M, Rollings S, Young D, et al. Cognitive-behavioral treatment of school-refusing children: a controlled evaluation. J Am Acad Child Adolesc Psychiatry 1998; 37:395-403.
28. Barlow DH, Beck JG. The psychosocial treatment of anxiety disorders: current status, future direction. In: Williams JB, Spitzer RL, eds. Psychotherapy research: where are we and where should we go?: proceedings of the 73rd Annual Meeting of the American Psychopathological Association, New York City, March 3-5, 1983. New York: Guilford Press, 1984:29-69.
29. Last CG, Hansen C, Franco N. Cognitive-behavioral treatment of school phobia. J Am Acad Child Adolesc Psychiatry 1998;37:404-11.
30. Bernstein GA, Garfinkel BD, Borchardt CM. Comparative studies of pharmacotherapy for school refusal. J Am Acad Child Adolesc Psychiatry 1990;29:773-81.
31. Klein RG, Koplewicz HS, Kanner A. Imipramine treatment of children with separation anxiety disorder. J Am Acad Child Adolesc Psychiatry 1992;31:21-8.
32. Compton SN, Grant PJ, Chrisman AK, Gammon PJ, Brown VL, March JS. Sertraline in children and adolescents with social anxiety disorder: an open trial. J Am Acad Child Adolesc Psychiatry 2001;40:564-71.
33. Emslie GJ, Heiligenstein JH, Wagner KD, Hoog SL, Ernest DE, Brown E, et al. Fluoxetine for acute treatment of depression in children and adolescents: a placebo-controlled, randomized clinical trial. J Am Acad Child Adolesc Psychiatry 2002;41:1205-15.

34. Riddle MA, Bernstein GA, Cook EH, Leonard HL, March JS, Swanson JM. Anxiolytics, adrenergic agents, and naltrexone. J Am Acad Child Adolesc Psychiatry 1999;38:546-56.

Copyright © 2003 by the American Academy of Family Physicians.
This content is owned by the AAFP. A person viewing it online may make one printout of the material and may use that printout only for his or her personal, non-commercial reference. This material may not otherwise be downloaded, copied, printed, stored, transmitted or reproduced in any medium, whether now known or later invented, except as authorized in writing by the AAFP. Contact afpserv@aafp.org for copyright questions and/or permission requests.