Impact of adolescent anxiety disorders on education

An exploration of the impacts of adolescent anxiety disorders on secondary educational outcomes.

The context and initial broad area / theme for study

The board theme of this study is to explore the types of anxiety disorders experienced by adolescents and the impact this has on their education. The study will also look at implications of anxiety on classroom teachers looking at strategies in which they can try and reduce anxiety and improve educational outcomes. The research will then focus more sharply on school refusal. Considering the possible reasons and causes of school refusal and the impacts school refusal can have on educational, social and lifelong outcomes. The research will take a critical approach to literature already written in this area to draw out any common themes in cases of school refusal. The research will also analyse the literature to examine any practical approaches on how to encourage these pupils to attend school and improve their educational and life experiences.

Review of key readings that underpin the investigation
What is anxiety and what are the types of anxiety disorders?

The Department of Education (2016) offers brief definitions of anxiety and the types of anxiety disorders experienced in childhood and adolescents. This is also supported by the World Health Organisation (2016) and the ICD10 diagnostic tool as well as the American Psychiatric Association Diagnostic and statistical manual of mental health (DSM-5). – Anxiety is defined as an emotional disorder which has an array of symptoms including; breathlessness, fearful, irritability, panicky, fidgety, sickness, tense or having difficulty sleeping. These references will be used as a first point of call in

defining and laying out the symptoms of the types of anxiety disorders experienced by adolescents and children.

Criticisms of diagnostic tools – mental health is a complex phenomenon in which we have relatively little understanding. The diagnostic tool is a classificatory system and Banzato (2008) states that the diagnostic categories failed to be validated and a large debate around the classifications descends around the separation of the boundaries between different disorders. This suggests that using the diagnostic tools on their own may lead to an over identification of mental health disorders, classifying behaviours that don't necessarily need to be classified will increase the diagnoses of disorders. Further criticisms as well as support of the DSM-5 has been offered by NHS England (2013) who state that there are two main interrelated criticisms, for example, during the revision process of DSM-V to the DSM-5 pharmaceutical industry had a large influence on what was to be included. In addition, the DSM-5 contributes to the medicalisation of behaviour and mood that would not necessarily have or need a diagnosis.

Morris and March (2004) – offers an in-depth discussion of childhood anxiety disorders including; Generalized Anxiety Disorder, Specific Phobia, School Refusal, Separation Anxiety Disorder, Social Anxiety disorder, OCD, Panic disorder and PSD. The discussions and findings in this book are supported by Beidel and Alfano (2011). These sources will also be used in the defining of mental health disorders in children and young people. These sources also provide useful information on prevalence rates as well as the treatment of childhood anxiety disorders.

Prevalence and statistics around anxiety in childhood and adolescents

Merikangas, Et al (2010) – Anxiety disorders were the most common condition (31. 9%) the median age of onset for this disorder was 6 years old. Lifetime prevalence – 25. 1% of 13-18-year-old. Statistical difference in sex with females at 30. 1% and males at 20. 3%. *United States.*

Department of Health (2015) – 3. 3% or about 290, 000 children and young people have an anxiety disorder. Exposure to bullying is also associated with elevated rates of anxiety, depression and self-harm in adulthood.

Goodman and Scott (2012) – anxiety disorders, affect roughly 4-6% of the general population. Roughly 5% of referrals to child and adolescent mental health services present with refusal to attend school associated with anxiety or misery. Around 4-8% of children and adolescents have clinically signiï¬cant anxiety disorders that cause substantial distress or interfere markedly with everyday life. This makes anxiety disorders the second commonest group of psychiatric disorders among children and adolescents. The effects of gender and age on prevalence vary from one anxiety disorder to another. The three most common anxiety disorders are speciï¬c phobias, separation anxiety disorder and generalised anxiety disorder. Social anxiety disorder and panic disorder are less common, as is post-traumatic stress disorder.

Criticism of these statistics – statistics such as these have played an important role in the development of mental health policies (Banzato, 2008). However, geographical and cultural variations in the use of the diagnostic

tools means comparisons across/within countries, regions and cultures is difficult (Banzato, 2008).

School Refusal – What is it? What causes it? Statistics surrounding it.

Thambirajah et al (2008) – Most children and young people go through occasional, infrequent and temporary non-attendance in school at some point in their school career. School attendance (children can be educated at home if approved by the LEA education officer) in the UK is compulsory for all young people under the age of 16 (young people under 18 have to be in some sort of Education, Training or Work). The issue of school attendance is currently at the focus of intense activity in schools, LEAs and the press. The most recent media interest surrounds the removal of children and young people from school for family holidays. This, until recently, resulted in fines given to parents/carers of these children. The term school refusal has been used to refer to the group of children who are reluctant to or fail to attend school for emotional reasons (Thambirajah et al, 2008). Thambirajah et al, (2008) clarifies the different terms used to describe different groups of children who fail to attend school, these terms are based around the core characteristics as they are currently understood by authorities and researchers and include; truancy, parentally condoned absence, school phobia, separation anxiety and school refusal. Official figures do not take school refusal into account and therefore there are no official estimates of the extent of the problem. As well as this it is hard for professionals and teachers to be aware of the problem this is due to; lack of awareness of the extent and impact of school refusal, difficulties in distinguishing school refusal from other groups, invisibility of these children, excluding medical

conditions, blaming parents. Kahn and Nursten (1968) also provide an in depth analysis of the psychosocial problems that can lead to school refusal.

Kearney (2008) states that there are a range of contextual risk factors as well as psychological factors can lead to school refusal and high absent rates include; homelessness and poverty, teenage pregnancy, school violence and victimisation, school climate and connectedness, parental involvement, family and community variables.

Lignefeller and Hartung (2015) – Discuss various statistics surrounding school refusal in the US and the factors that surround school refusal. These can include; School safety, bullying, pressure of academic achievement. The article then looks into the problems that school refuser face due to the lack of attendance. Implications and treatments for school refusal are also discussed. The findings in this article are supported by Nuttall and Woods (2013).

Kearney and Bates (2005) provides a summary of the characteristics of youths with school refusal behavior and explores the common assessment and treatment methods that have been designed to curb this behavior.

Kearney (2006) evaluated The School Refusal Assessment Scale-Revised (SRAS-R). This is an instrument designed to evaluate the relative strength of four functional conditions of school refusal behavior in youth. Despite the presence of a small number of items that may detract from the scale, strong support was found overall for the four-factor structures of the SRAS-R-C and SRAS-R-P. These data provide support for the functional model of school

refusal behavior in general and the discriminant validity of the SRAS-R in particular.

School Refusal – Implications

Sewell (2008) states that school refusal can have significant short term and long term consequences, for example; poor academic performance, family difficulties, worsening peer relationships, academic underachievement, employment difficulties and increased risk of psychiatric illnesses. Supported by Maynard et al. (2015).

School Refusal – Interventions/treatments

Lauchlan (2003) – discusses the effectiveness of interventions and the reasons for successes and failures. There are a range of interventions and treatments for example; relaxation training, cognitive restricting or self-statement training, exposure, medication, social skills training, parent/teacher training etc. This articles provides a summary and critical analysis of the above interventions. Lingenfelter and Hartung (2015) provides a critical analysis of this and states that there is a strong focus on therapy and counselling with trying to treat school refusal behaviors. These can be supplemented with medication.

Revised research question
From my initial review of the literature there are clear and defined areas of research conducted in this area. However, due to the comprehensive nature of the research in this area, there seems to be a lack of clarity surrounding three particular areas. Therefore, my revised research questions are:

- What is known to be the main reasons behind school refusal in children and young people?

- What is known to be the implications for children and young people's educational outcomes as a result of school refusal?

- What are the different treatment/intervention strategies for school refusers and how effective are these?

Rationale for the research design

For this research project I have chosen to do a systematic review of the literature. The main reasons for choosing this type of research design is the sensitive nature of the topic (anxiety disorders) and the barriers that would be placed in doing primary research with students with anxiety issues.

In addition, there is already a wide selection of literature on this topic area however, there is a lack of drawing this literature together to critically analyses it from different perspectives. Systematic reviews are attempts to review and synthesis existing research in order to answer specific research/review questions (Andrews, 2005). This area has been the center of ongoing in depth research from early 1930s to the present day. The research looks into the various reasons for school refusal (although this has been acknowledged that each case is individual, there are a variety of common themes that have emerged). The research has also investigated several " treatments" or " interventions" of school refusal. However, there is little research that draws these ideas together and critically analyse them. The large amount of research in the area means that creating more primary research would be pointless, instead I believe that there is a need to draw this literature together to compare, contrast and analyse it and this would be

more beneficial to this area of research. This idea is supported by Klaveren and Inge De Wolf (2013) who states that systematic reviews give structure to the findings of larger amounts of empirical studies and act as an informant to the reader on the results and effectiveness of previous studies.

Systematic reviews are often viewed in a skeptical way, especially in the field of educational research. For example, Andrews (2005) questions the idea of reviewing research, he suggests that not all research is worth reviewing and therefore a systematic review can place importance on less significant research. In addition, Bryman (2012) states that there are suggestions of applicability of a systematic review to certain types of literature. This is due to early systematic reviews being concerned with the exploration of certain independent variables and their effects. However, Bryman (2012) also states that there has been a shift in the use of systematic reviews and that they are now considered useful tools in a range of research areas. In addition, Mulrow (1994) states that professionals, researchers and policy makers need systematic reviews to be able to efficiently integrate existing information and provide data for rational decision making. Mulrow (1994) also states that the explicit methodology used in a systematic review limits bias and, hopefully, will improve the reliability and accuracy of the conclusions drawn. Bryman (2012) states that due to the transparency of the methodology adopted and outlined in the research, it provides a degree of replicability to the study and therefore increasing the validity and reducing the bias of the study.

Due to the nature of this research, ethical issues are kept to a minimum. No human participants will be used in this research and participants from the

articles analysed are already anonymised and informed consent was obtained. Additionally, there is no need to gain gatekeepers permission for the use of the articles in the study as they are available on the internet. The articles are accessed via institutional log-on but can be purchased by the public. To reduce ethical issues further I will take care to be professional in my writing/reporting for example by criticising the literature politely and in a constructive manner.

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