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Disabilities Exhibited by Children and Adolescents That Refuse to Go to School

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ABSTRACT

The aim of the study was to investigate what functional difficulties young people who refuse to go to school experience in their everyday lives. Research questions were what difficulties do young people who refuse to go to school experience? Are there differences between boys and girls? The study is a retrospective journal study with 28 Swedish youngsters based on Strengths & Difficulties Questionnaire (SDQ). Major findings were about somatic symptoms, emotional distress, loneliness, distinct gender roles, less mature and risk behavior. Although the school, social services and children- and adolescent psychiatry largely agree on the complexity of adolescents being absent from school, it seems difficult for the organizations to agree on adequate solutions.

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KEYWORDS

Disabilities; psychiatric symptoms; SDQ; children and adolescent psychiatry

Introduction

School refusal in recent years

In recent years, school refusal behavior in children and adolescents has been highlighted as both serious and extensive (Official Reports of the Swedish Government, SOU, 2016, p. 94; Socialstyrelsen & Skolverket, 2016). Children and adolescent psychiatry (CAP) currently have great difficulties in caring for and providing the right support to young people who do not attend school. It has been found that the problematic picture of young people who do not go to school is complex (Ek, 2018; Ek & Eriksson, 2013; Heyne et al., 2014; Kearny, 2008; Rudolph, 2002; Socialstyrelsen & Skolverket, 2016). According to Sundell and Karlberg (2004), these young people have different characteristics. They are characterized by low self-esteem, low perceptions of their own school performance and increased sensitivity towards school failures. These traits, in turn, increase the risk of suffering from depression or anxiety problems. Ek and

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Eriksson (2013) describe that the coexistence between separation anxiety and depression is high for truants. Several different factors, including psychological, biological and social, affect the development of depression and anxiety. Anxiety and worry, perfectionism, poor self-confidence, a tendency to dwell on problems instead of dealing with them, as well as a tendency to take things on and blame themselves are risk factors for depression. Often, young people with depression have suffered from various anxiety disorders during younger years (Barlow, 2008; Eriksson & Ek, 2017; Hoare et al., 2017; Kearney & Diliberto, 2014; Landstinget Uppsala Län, LHU, 2015; Official Reports of the Swedish Government, SOU, 2016, p. 94; 1998, p. 31).

Mental illness among children and adolescents

Mental illness is common among children and adolescents. Epidemiological studies indicate that 10–25% of children and adolescents suffer from psychological difficulties of such a kind and degree that both the child or adolescent and their surroundings suffer as a consequence (Allison et al., 2014; Blair et al., 2013; Lahey et al., 1999; Socialstyrelsen & Skolverket, 2016). Several studies show that around 5–10% of all children and adolescents meet the diagnostic criteria for one or more anxiety disorders (Allison et al., 2014; Blair et al., 2013; Ek & Eriksson, 2013; Forster, 2009). The prevalence of depression in children and adolescents seems to be more frequent than previously believed. For children of pubescent age, the depression rate is set at 0.5–2.0% (Allison et al., 2014; Forster, 2009; Swedish Agency For Health Technology Assessment And Assessment of Social Services, SBU, 2005; Olsson & von Knorring, 1997, 2007). Other studies show that the prevalence of actual depression among 16–17-year-olds is 6%, just over 9% among girls and just under 2% among boys (Olsson, 1998; Socialstyrelsen & Skolverket, 2016).

The prevalence of behavioral disorders among children and adolescents

The prevalence of behavioral disorders among children and adolescents varies between countries and studies, but is estimated to be about 3% for those aged 4–18-years-old, with a shift towards the older age group. Behavioral disorders occur 2–4 times as often in boys than in girls (Blair et al., 2013). Mental illness often affects the individual's social interaction, learning ability, and self-esteem negatively. This is, of course, critical for children and adolescents and can have negative consequences for the future through, for example, anxiety disorders, especially separation anxiety, panic syndrome, excessive anxiety, and social phobia that can lead to the child

avoiding school completely or partly (Ek & Eriksson, 2013; Friberg et al., 2015; Leonard et al., 2015; Maynard et al., 2017; Salokangas et al., 2002). According to research on gender, we are all influenced by our conceptions and expectations of the different genders based on the prevailing gender norms. When it comes to school pupils, there is a general picture of nice girls and disturbing boys, and that girls are relationship-oriented and boys activity-oriented. The gender norm tells us that girls are more study-motivated than boys, while research shows that girls more often feel stressed about school work. Boys, on the other hand, experience a greater degree of peer pressure that is directed towards an overly strong commitment to school success (Butler, 2005; Friberg et al., 2015; Wiklund et al., 2012; Van Roy et al., 2006; Official Reports of the Swedish Government SOU, 2016, p. 94, 2010, p. 79).

Teenagers and depression

The teenage years are for many young people a period of ruminations. When a teenager is constantly sad, gloomy and experiences life as hopeless, joyless, and pointless, there is reason to suspect depression. This is part of the picture where the depressed teenager tries to hide his or her problems, is ashamed, feels guilty and cannot bring him or herself to seek help. He or she thinks that nothing can help, and hides his or her difficult situation. Therefore, it often takes a long time for those in their surroundings to realize that a teenager is depressed. Many young people will never come for treatment. Severe depression is evident through a clearly impaired ability to function in several important areas, where missing schooling is an example (Gustafsson & Modin, 2012; Hoare et al., 2017; Kearney & Diliberto, 2014; Official Reports of the Swedish Government, SOU, 2016, p. 94). In addition to experiencing fear or anxiety, psychiatric symptoms of anxiety disorders are the reactions and actions the youth takes to escape anxiety, such as not going to school. The aim of this study is use journal data to find patterns in young people who do not attend school. Few county councils have had the opportunity to study in detail the documentation and medical records in Child and Adolescent Psychiatry (CAP). This study thus seems relatively unique as it focuses on a specific problem group, truants, and what characterizes this group viewed from a clinical perspective, based on journal data. A central question has to do with what the problems look like for these young people in everyday life.

Aim

The aim of the study was to investigate what functional difficulties young people who refuse to go to school experience in their everyday lives.

Research questions

What difficulties do young people who refuse to go to school experience?
Are there differences between boys and girls?

Hypothesis

In this study, we expected that both male and female participants would score negatively on: emotional symptoms, conduct problems, hyperactivity, peer problems and prosocial behavior. However, we expected the males to have more negative SDQ score on the emotional symptoms and the total difficulty score as previous research indicate a gender difference (Goodman, 1999; Lundh et al., 2008).

Material and method

Participants

In total, 28 Swedish youngsters (11 boys and 17 girls; range: 12–17 years) were recruited from a child and adolescent psychiatric specialist clinic in Sweden. The adolescents in the study came from a mid-sized city in Sweden with demographic heterogeneity, with youth from both middle class and socially vulnerable families.

Procedure

The study is a retrospective journal study. A retrospective study has been chosen for practical reasons as it facilitates access to data. Hellevik (1984) argues that the advantage of retrospective study is that the researcher uses existing material, that is, the researcher does not need to retrieve the information him or herself. The selection was strategic and included all young people from an outpatient clinic during a year where the first cause of contact was truancy and school refusal. The children were asked to complete the Strengths and difficulties questionnaire (SDQ) during the initial mapping conversation. All the youngsters had a known shirk issue. The adolescents who participated had various psychiatric diagnoses such as depression, social phobia, autism, ADHD, and ADD.

Ethical considerations

All information obtained from and about the individual have been treated with confidentiality. This means, in part, that data have not or will not be disclosed to outsiders, and that there is no possibility of identifying an individual when the results are presented in a scientific article. Everyone who

works in healthcare has a duty of confidentiality . The material is stored so that no unauthorized person can access it. The entire data collection has taken place in pediatric and adolescent psychiatry premises and computer systems. Data and the code key will be saved in accordance with current regulations and then destroyed after the article has been published (). This means that there are laws and regulations that protect the child and their integrity (Kvale, 1997; Olsson & Sörensen, 2007).

Electronic medical record

Melior is an electronic medical record and documentation system that has existed since the beginning of the 1990s and is used by most medical institutions in Sweden today. The system, which is used by both outpatient and inpatient care, records the patient's reason for contact, health care, and diagnosis/diagnoses.

International Statistical Classification of Diseases and Related Health problems (ICD)

The International Classification of Diseases (ICD) is an international standard diagnostic classification for all diseases published by the World Health Organization (WHO). The psychiatric illness section of the system in the ICD starts with the letter F. The F-diagnoses are symptom diagnoses. Similarly, basic diagnoses can be combined with explanatory Z-diagnoses that are usually of a social nature. The Z-diagnosis is also used in investigations since the youth has not yet received a specific diagnosis. "Without specification" is used when the condition in the individual case deviates to some extent and when other specified diagnosis is not applicable (World Health Organization, ICD 10, 2009).

Measures

The Swedish version of SDQ was used to measure the participants' pro-social behavior ($\alpha = .54$), emotional symptoms ($\alpha = .79$), hyperactivity ($\alpha = .78$), peer problems ($\alpha = .69$), and conduct problems ($\alpha = .69$). All the variables except for pro-social behavior were added together to generate a total difficulties score ($\alpha = .69$). Items 7, 11, 14, 21, and 25 were re-coded in line with the suggested scoring algorithm (Goodman, 1999). Further, the items were re-coded in line with suggested variable coding (Goodman, 1999). The response scale ranged from 0 (not at all), 1 (somewhat true) and 2 (certainly true) (Figures 1 and 2).

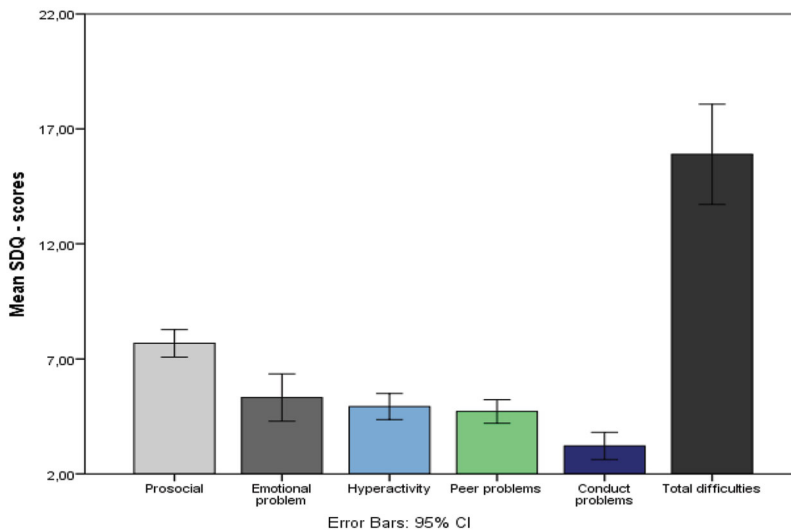


Figure 1. Descriptive statistics on SDQ. $N=28$. Response scale was recoded into total SDQ score for each variable.

Prosocial behavior:

Pro-social behavior was measured with five items ($\alpha = .54$):

“Considerate of other people’s feelings,” “Shares readily with other youth, for example, CD’s, games, food,” “Helpful if someone is hurt, upset or feeling ill,” “Kind to younger children,” “Often offers to help others (parents, teachers, children).”

Emotional symptoms

Emotional symptoms was measured with five items ($\alpha = .79$): “Often complains of headaches,” “stomach-aches or sickness,” “Many worries or often seems worried,” “Often unhappy, depressed or tearful,” “Nervous in new situations,” “Easily loses confidence,” and “Many fears, easily scared.”

Hyperactivity

Hyperactivity was measured with five items ($\alpha = .78$): “Restless, over-active, cannot stay still for long,” “Constantly fidgeting or squirming,” “Easily distracted,” “concentration wanders,” “Thinks things out before acting,” and “Good attention span, sees chores or homework through to the end.”

Peer problems

Peer problems was measured with five items ($\alpha = .69$): “Would rather be alone than with other youths,” “Has at least one good friend,” “Generally

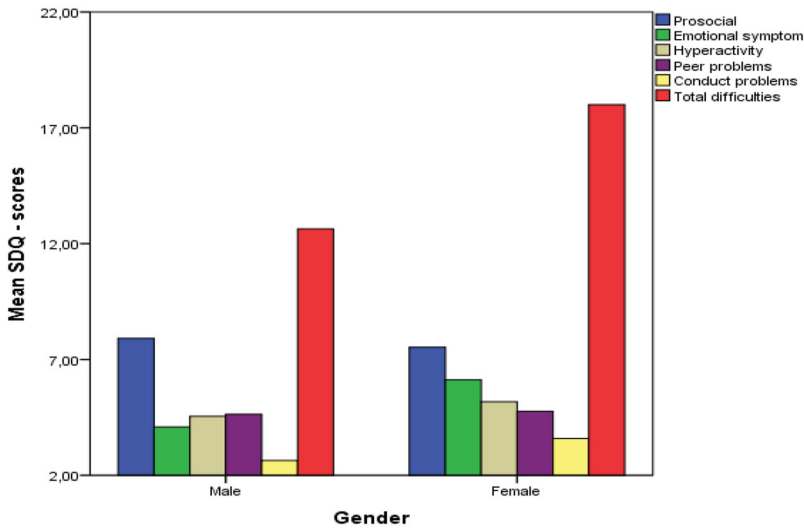


Figure 2. Descriptive statistics on SDQ and gender. $N = 28$. Response scale was recoded into total SDQ score for each variable.

liked by other youths,” “Picked on or bullied by other youths,” and “Gets along better with adults than with other youths.”

Conduct problems

Conduct problems was measured with five items ($\alpha = .69$): “Often loses temper,” “Generally well behaved, usually does what adults request,” “Often fights with other youths or bullies them,” “Often lies or cheats,” and “Steals from home, school or elsewhere.”

Total difficulties

Total difficulties were measured with 20 items ($\alpha = .72$). The total difficulties score included the emotional symptoms, hyperactivity, peer problems, and conduct problem items: “Often complains of headaches,” “stomach-aches or sickness,” “Many worries or often seems worried,” “Often unhappy, depressed or tearful,” “Nervous in new situations,” “Easily loses confidence,” and “Many fears, easily scared,” “Restless, overactive, cannot stay still for long,” “Constantly fidgeting or squirming,” “Easily distracted,” “concentration wanders,” “Thinks things out before acting,” and “Good attention span, sees chores or homework through to the end,” “Would rather be alone than with other youths,” “Has at least one good friend,” “Generally liked by other youths,” “Picked on or bullied by other youths,” and “Gets along better with adults than with other youths,” “Often loses temper,” “Generally well behaved, usually does what adults request,” “Often

Table 1. Scale inter-correlations and descriptive statistics.

Variable	1	2	3	4	5
1 Prosocial	–				
2 Emotional symptoms	–.09	–			
3 Hyperactivity	–.31	.04	–		
4 Peer problems	.41*	.23	–.22	–	
5 Conduct problems	–.16	.06	.12	–.06	–
Mean	7.68	5.32	4.93	4.71	3.21
SD	1.54	2.65	1.46	1.32	1.52
α	.54	.79	.78	.69	.69

$N = 28$. Higher scores indicate higher levels of each measure, * $p < .05$ (2-tailed).

Table 2. Means and standard deviation of SDQ scores across gender conditions.

Variable	Male		Female		Cohen's d Male v Female
	M	SD	M	SD	
Prosocial	7.91	1.64	7.53	1.50	.24
Emotional symptoms	4.10 ^a	3.02	6.11 ^b	2.11	–.77
Hyperactivity	4.55	1.04	5.18	1.67	–.45
Peer problems	4.64	1.29	4.76	1.39	–.08
Conduct problems	2.64	1.21	3.59	1.62	–.66
Total difficulties	12.64 ^a	5.59	18.00 ^b	4.68	–1.03

$N = 28$. a and b differ significantly $< .05$ from each other.

fights with other youths or bullies them,” “Often lies or cheats,” and “Steals from home, school or elsewhere” (Tables 1 and 2).

Results

Data analysis

Post-hoc power analysis was performed comparing previous SDQ mean scores compared to our study results to demonstrate the long-run probability of obtaining significant results in exact replication studies (Yuan & Maxwell, 2005). *Pro-social results* in previous studies (1.8–7.7) and in our study (male 7.9; 74.8%; female 7.5; 86.3%), *emotional symptoms* in previous studies (2.4–2.9) our study (male 4.1; 49.4%; female 6.1; 100%), *hyperactivity* in previous results (2.5–3.8) and in our study (male 4.5; 41.5%; female 5.2; 83%), *peer problems* in previous studies (1.8–2.7) and in our study (male 4.6; 93%; female 4.8; 99.6%), *conduct problems* in previous results (2.4–3.6) and in our study (male 2.6; 3.8% female 3.6; 28.9%) and *total difficulties* in previous studies (6.4–13) and in our study (male 12.6; 35.6%; female 18; 95.7%).

A Pearson product–moment correlation coefficient (two-tailed) was computed to measure the relationship between the variables used in the SDQ, including emotional symptoms, hyperactivity, peer problems and conduct problems. There was a non-significant negative correlation between prosocial and emotional problems, $r = -0.92$, $n = 28$, $p = .64$. There was also a negative non-significant correlation between prosocial and hyperactivity, $r = -0.31$, $n = 28$, $p = .11$. There was a positive significant correlation

between prosocial and peer problems, $r = .41$, $n = 28$, $p = .03$. There was a negative non-significant relationship between prosocial and conduct problems, $r = -.16$, $n = 28$, $p = .42$.

Analysis of variance (ANOVA) was conducted using PASW (Predictive Analytics Software) statistics 23 to analyze the dependent variables in the SDQ instrument. We measured the dependent variables related to prosocial behavior, emotional symptoms, hyperactivity, peer problems, conduct problems, and total difficulties. The independent variable was gender (e.g. male, female). Cohen's d was used to measure effect size to compare the gender variable divided by the average of their standard deviation. According to Cohen, Cohen, West, and Aiken (2003), $d = .02$ is considered a small effect size, $d = 0.5$ is considered a medium effect size and $d = .08$ is considered a large effect size.

An ANOVA showed an overall non-significant difference between gender on the variable *prosocial*, $F(1, 26) = .40$, $p = .53$, $\text{partial } \eta^2 = .015$, male ($M = 7.91$, $SD = .47$), and female ($M = 7.53$, $SD = .38$). There was an overall significant difference between gender on the variable *emotional symptoms*, $F(1, 26) = 4.39$, $p = .04$, $\text{partial } \eta^2 = .14$, male ($M = 4.09$, $SD = .75$), and female ($M = 6.12$, $SD = .61$). There was a non-significant difference between gender on the variable *hyperactivity*, $F(1, 26) = 1.25$, $p = .27$, $\text{partial } \eta^2 = .04$, male ($M = 4.55$, $SD = .44$), and female ($M = 5.18$, $SD = .35$). There was a non-significant difference between gender on the variable *peer problems*, $F(1, 26) = .06$, $p = .80$, $\text{partial } \eta^2 = .002$, male ($M = 4.64$, $SD = .41$), and female ($M = 4.77$, $SD = .33$). There was also a non-significant difference between gender on the variable *conduct problems*. $F(1, 26) = 2.77$, $p = .11$, $\text{partial } \eta^2 = .10$, male ($M = 2.64$, $SD = .44$), and female ($M = 3.59$, $SD = .36$). There was a significant difference between gender on the variable *total difficulties*, $F(1, 26) = 7.54$, $p = .01$, $\text{partial } \eta^2 = .23$, male ($M = 12.64$, $SD = 1.52$), and female ($M = 18.00$, $SD = 1.22$).

SDQ record sheet

We used the SDQ record sheet, which is a standardized categorization of the SDQ score on psychological symptoms (i.e. normal, borderline, and abnormal) to define the extent to which our participants were at risk of developing psychiatric symptoms. According to the SDQ Record sheet, the female participants were categorized as abnormal on emotional symptoms, that is, symptoms related to “somatic symptoms,” “worries,” “unhappiness,” “nervous in new situations,” and to have “many fears.” The male participants were defined in the normal category. We also found the female participants to be defined as borderline on conduct problems, that is, symptoms related to “tempers,” “obedient,” “fights or bullies,” “lies or

cheats,” and “steals.” The male participants were defined as in the upper level of the normal categorization, and were close to the abnormal category. Further, we found the female participants to be defined as borderline on hyperactivity, that is, related to “restless,” “fidgety,” “easily distracted,” “thinks before acting,” and “good attention.” In contrast, we found the male participants to be categorized in the upper level of the normal category. We found both males and females to be in the borderline category on peer problems. This pertains to problems related to “solitary,” “has good friends,” “picked on or bullied,” and “better with adults than with children.” Interestingly, both the male and the female participants were in the normal category on pro-social behavior, that is, “considerate,” “shares readily,” “helpful if someone is hurt,” “kind to younger children,” and “often volunteers.” Both female and male participants were categorized as abnormal on total difficulties, that is, related to all the SDQ items except for the items related to pro-social behavior.

Discussion

In this study, we were interested in measuring the SDQ items in close relation to adolescents having a shirk issue. We found that there were gender differences in the SDQ scores on emotional symptoms and total difficulty scores. We expected the adolescents to score negatively on the SDQ record sheet as these youngsters already have a negative behavior related to a shirk issue. Our findings are in line with previous research by Friberg et al. (2015).

Somatic symptoms

SDQ suggests that the female participants appear to be in the clinical/significant range, in terms of emotional symptoms related to “somatic symptoms,” “worry,” “accidents,” “nervous in new situations,” and to have “many fears.” The male participants, on the other hand, appear to be within a normal range. For the female participants, clinical intervals also appeared for behavioral problems based on the categories “obedient,” “fight or bully,” “lie or cheat,” and “steal.” The male participants, on the other hand, appear to be within normal range. The fact that girls experience somatic symptoms to a greater extent than boys is already known. According to Olsson and von Knorring (1997), Van Roy et al. (2006), and Salokangas et al. (2002), girls experience more somatic problems than boys. Girls experience stress to a greater extent than boys, which in itself can result in headaches, stomach-aches and difficulty sleeping. It has also been

found that girls reflect more than boys and thus are affected by physical symptoms.

Loneliness

The study further showed that both male and female participants experienced peer problems related to the categories “loneliness” and “had better contact with adults than with peers.” Interestingly, both male and female participants were within the normal range of social behavior based on the categories “considerate,” “helpful,” “kind to younger children.” Both the male and female participants appear to be within a significant range of total difficulties. According to Ek and Eriksson (2013), several of the children and adolescents, who are absent from school, have various disabilities that affect social interaction with peers. Thus, it becomes easier to make contact with younger children or adults. The fact that girls in general feel psychologically worse than boys is already a known phenomenon (Allison et al., 2014; Official Reports of the Swedish Government, SOU, 2016, p. 94; Olsson & von Knorring, 2007). This is also in line with this study, where the results show that girls had significantly higher total points on the Strengths and Difficulties Questionnaire than the boys. However, when it comes to prosocial behavior, boys in all grades are over-represented (Landstinget Uppsala Län, LHU, 2015). Similar results are also shown in a Swedish survey by Gustafsson and Modin (2012) which includes young people in grades 6–9.

Emotional distress

An interpretation that girls are more likely to experience emotional distress than boys may be that girls more often report internalizing symptoms such as anxiety, depression, and worry than boys (Gustafsson & Modin, 2012). Similarly, it is more common for boys to exhibit externalizing symptoms and negative behavior, which includes hyperactivity, attention and behavioral disorders (Official Reports of the Swedish Government, SOU, 2010, p. 79). This is congruent with the results of this study, where it appears that boys to a greater extent than girls had a lack of social behavior. One conceivable explanation that girls perceive emotional symptoms to a greater extent may be that they generally have an earlier onset of puberty than boys, which in itself means major hormonal change. Another aspect to take into account is that girls tend to have higher demands related to school work as they are entering into adulthood, which Leonard et al. (2015) also highlight. According to Leonard et al. (2015), girls are psychologically worse off with increasing age. One explanation may be that awareness

regarding finding one's identity increases as adolescents grow older; the awareness of finding one's identity increases, which can contribute to temporarily impaired mood (Allison et al., 2014; Lahey et al., 1999; Swedish Agency for Health Technology Assessment and Assessment of Social Services, SBU, 2005; Official Reports of the Swedish Government, SOU, 1998, p. 31).

Girls unhappy in school

The girls who participated in the study from LHU (2015) described that they were unhappy in school, and they scored high on the sub-scale peer relationship problems. An equivalent result is also found in a study by Rudolph (2002), where teenage girls were shown to be more sensitive to stress for peer relationship problems, which in turn resulted in mental ill health in the form of worry, anxiety, and depression. This pattern can be judged as a gender-typical behavior, which is also demonstrated by Gustafsson and Modin (2012). We can conclude that gender roles in school are still distinct and that there are female and male ways for children and young people to signal to the outside world that they are not doing well (Official Reports of the Swedish Government, SOU, 2016, p. 94). As society develops, new norms and new ways of looking at things will emerge, of which gender is a factor. Thus, the view of what boys and girls will and should do is changed (Butler, 2005). It must be acceptable for children and adolescents to show that they feel bad in different ways and rather on the basis of personality than gender (Official Reports of the Swedish Government, SOU, 2016, p. 94).

Behavioral problems and risk situations

If behaviors that are either of an emotional or outgoing nature are not noticed and addressed in a timely manner, it can lead to fatal consequences. For children with behavioral problems, the risk of crime and abuse increases; further, for children with emotional problems, it has to do with depression and mental illness as a whole. It is of utmost importance to pay attention to these children, not to overlook them but to try to help them change their behavior. It is also important to see boys and girls as different individuals and to be open because there are different ways to show that you are not doing well (Official Reports of the Swedish Government, SOU, 2016, p. 94).

The SDQ, which is used in the initial treatment contact at CAP, shows that young people who do not go to school often experience concentration difficulties in school but not at home. Could it be that young people have

an easier time concentrating at home where the requirements are lower? The form also shows that young people often perceive themselves as social and empathetic while being lonely and lacking friends. Furthermore, it appears that they would rather spend time with children younger than themselves.

Not as mature as their peers

Maybe the adolescents are not as mature as their peers and therefore seek contact with younger children? In addition, many are afraid and insecure about new situations, but with younger children they can more easily control and decide, which gives them increased control in different situations. Further, SDQ shows that adolescents often have difficulty controlling their anger and that they can also become outspoken. My thoughts on this are that adolescents have not learned to handle their anger in a functional way; perhaps, they have not had good role models? The interaction between biological and psychological vulnerability factors such as the growing environment, family relationships, and own experiences can contribute to the development of anxiety disorders, with lack of schooling as a result (Official Reports of the Swedish Government, SOU, 2016, p. 94).

Psychological treatment

Previous studies show that younger children who remain at home (7–11 years) respond better to psychological treatment compared to older children who remain at home (12–18 years). The reasons for this may be several, among other things, the absence is often higher for older children who do not go to school. The degree of depression and anxiety disorders seems to be higher as well as the problem has been going on for a long time (Heyne et al., 2014). It has previously been debated whether reduced anxiety contributes to increased school attendance and vice versa, that is, increased school attendance contributes to reduced anxiety (Maynard et al., 2017). Maynard et al. further describe that many of the young people who do not go to school have emotional difficulties as well as difficulties with hyperactivity, which is something also described in this study. According to Eriksson and Ek (2017), school absence is an complex problem. The reasons for school absenteeism are individual, and the number of adolescents that are absent from school can have at least as many reasons. Among other things, the adolescent may have neuropsychiatric disabilities, emotional and/or social problems, or be special, low, or normally gifted. Although the school, social services and CAP largely agree on the complexity of adolescents being absent from school, it seems difficult for the

organizations to agree on adequate solutions. This is especially true, when it comes to responsibilities and obligations (Eriksson & Ek, 2017).

Continued research

It would be interesting to investigate how socioeconomic conditions affect school absenteeism. Are there statistical differences between those who come from more affluent neighborhoods with low unemployment than neighborhoods with high unemployment? It would also be useful to shed light on what adolescents themselves think about school absence.

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