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CASE REPORT

School refusal as the first presentation of adverse childhood events and autism spectrum disorder: A primary care case report

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ABSTRACT

Since the pandemic, school refusal has become an increasingly alarming issue, representing the emotional conflict manifested when a child refuses to attend school. This case study describes the management of a 13-year-old girl who presented to a primary care clinic with school refusal due to a history of adverse childhood events, leading to a diagnosis of a mood disorder and newly suspected high-functioning autism. This report shares a unique interplay between school refusal, adverse childhood events, and psychological disorders. The patient's complex comorbidities require individualized case formulation and effective management through parental and teacher support. Primary care physicians play an important role in identifying Adverse Childhood Events (ACEs) as a preventable cause of school refusal, to lead and coordinate a multidisciplinary team intervention activity for a favourable prognostic outcome.

1. INTRODUCTION

School serves as a vital medium for the bio-psychosocial development of children and adolescents. However, for some students, school becomes a source of distress, often manifested as school refusal. School refusal affects 1 to 5 % of children and adolescents globally at some stage in their educational years [1].

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It is defined as emotion-based avoidance of school attendance, which is distinct from truancy and usually related to behavioural and disciplinary issues [1,2].

In the United Kingdom, rates of chronic absenteeism have nearly doubled compared with pre-pandemic [3]. In Japan, 37.2 of every 1000 students miss more than 30 days of school per year for psychosocial reasons [4]. In Malaysia, although the data remain limited, the National Health and Morbidity Survey (NHMS) 2017 reported a rise in mental health issues such as depression among adolescents with school refusal as a possible cause [5].

Since the COVID-19 pandemic, there has been a significant increase in school-related anxiety and school refusal among children and adolescents, with contributing factors such as family dysfunction, exposure to trauma, and previously undiagnosed neurodevelopmental conditions [6,7].

Notably, children with autism spectrum disorder (ASD) are particularly vulnerable to school refusal. Over 30% of autistic children in England are identified as "persistent absentees" due to both exclusion from school and emotionally based school avoidance. In a study involving 947 parents reported that their child's school attendance difficulties were significantly related to school psychological distress, of which 92% of them were identified as having neurodivergent disorders [7].

This case emphasized the crucial need for early detection and intervention in school refusal, especially concerning the primary care role and multidisciplinary rehabilitation.

2. CASE PRESENTATION

Miss A, a 13-year-old girl, presented to a primary care clinic with her father due to a five-month history of school refusal. Her initial symptoms were palpitations and panic attacks, which later progressed to complete avoidance of school. She experienced unexplained fears and tears every morning, and the symptoms worsened if her parents made attempts to send her to school.

A more detailed history from her father revealed that she displayed symptoms suggestive of high-functioning autism spectrum disorder (ASD). She was hypersensitive to noise, had problems making friends at school, was quiet and not elaborative when communicating,rigid in her thinking patterns, and had limited interests. She has a special affection for anime drawing and spends hours on it. Academically, she was an average student. However, her parents and Miss A were coping well with her symptoms and never received any unfavorable school reports from her teachers. Miss A was the second of four siblings, of whom her siblings were well, except her younger brother, who was found to have dyslexia.

The family was living in harmony until the COVID-19 pandemic struck the world. They faced a challenging time during which her father lost his job, and her mother suffered a cerebrovascular accident resulting in right hemiparesis. Hence, Miss A took the caregiver's role in looking after the mother, which took a significant toll on her. She was mentally affected, withdrawing from family members, and began to show signs of low mood and anxiety. She felt continuous sadness, lost her interest in previously enjoyed activities, had hypersomnolence, and was unable to concentrate on schoolwork. She was grieving over her mother's condition. Self-harming behaviours such as biting her lips or lacerating her forearms seemed to give her temporary relief. She preferred being alone in her room, ruminating about her death and quietly ending her life. She also showed signs of separation anxiety, expressing intense fear that something would happen to her mother during her long hours at school. She preferred to be at home instead of at school.

Clinical examination revealed Miss A as a quiet, reserved and withdrawn adolescent. She had very limited eye contact with dry and cracked lips. She preferred to talk to her father instead of directly answering interview questions. Her vital signs were within the normal limits, and blood investigations were normal.

Miss A was diagnosed with major depressive disorder, with underlying adverse childhood events and autism spectrum disorder. She was prescribed Sertraline 25mg at night and Clonazepam 1mg when necessary. Psychoeducation sessions were provided to the parents mainly on their child's illness by outlining positive parenting strategies. Both parents and Miss A were scheduled for post-trauma psychological care with a counsellor who aimed to enhance their coping skills and resilience. Additionally, her father had discussed with the school principal and counsellor regarding her current problems and tried

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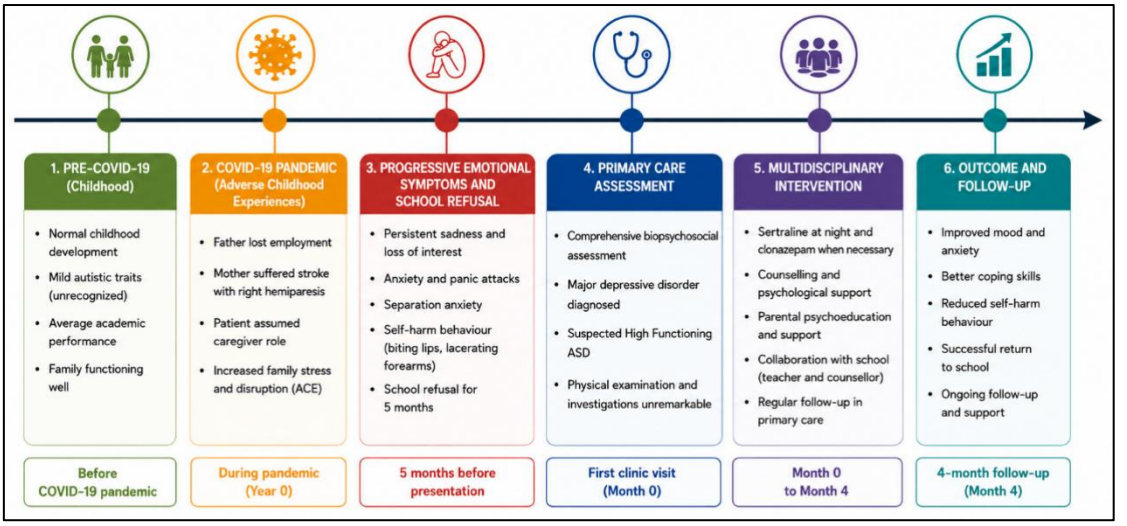
to help her come back to school. After four months of a multidisciplinary approach, involving robust parental and school support, Miss A successfully returned to school. Figure 1 summarises the patient's clinical timeline, illustrating the patient's clinical course from pre-pandemic functioning through exposure to adverse childhood experiences (ACEs) during the COVID-19 pandemic, the development of school refusal and psychological symptoms, primary care assessment, multidisciplinary intervention, and successful return to school after four months of follow-up.



Note: ACE, adverse childhood experience; ASD, autism spectrum disorder; MDD, major depressive disorder

Fig. 1. Clinical timeline of the patient's presentation, assessment, management, and outcome

Source: Siti Umi Fairuz Azmi et al. (2026)

3. DISCUSSION

School avoidance is linked to long-term emotional issues, such as depression and anxiety, poor academic performance, and an increased risk of school drop-out and suicide, especially in ASD [6,7].

This case report emphasized the need for a thorough evaluation, uncovering the root causes of the adolescent's school refusal, implementing appropriate interventions, and preventing adverse outcomes. In Miss A's case, parental job loss, maternal disability and familial stress are identifiable adverse childhood experiences (ACEs) that significantly influenced her emotional well-being.

A tool for ACEs in primary care, such as an adapted 8-item Bahasa Malaysia ACE questionnaire from the 10-item ACE questionnaire, is available for early screening for those presenting with school refusal that may have deeper psychiatric concerns, underscoring the need for immediate and thorough assessment in primary care settings. Regular screening can enable timely intervention, ultimately improving outcomes for affected adolescents [8,9].

Adverse childhood experiences are preventable. Children and adolescents witnessing or experiencing violence, experiencing neglect, or witnessing suicidal attempts or death may experience trauma [10,11]. Early trauma in childhood will increase risk for health morbidities, mental disorders, and social deprivation over the life course [8,9]. Miss A's psychosomatic symptoms were consistent with this

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pattern, exacerbated by pandemic-related stress and the caregiver's roles. Commonly, school refusal is present with nonspecific anxiety or worries, apprehension with palpitations when with others, and general sadness when requested to go to school [11].

From the thorough assessment, it was discovered that Miss A also showed some features suggestive of autism spectrum disorder (ASD) and trauma events which had amplified or mimicked the traits [12].

Diagnosis of ASD in adolescents is challenging. It requires a thorough history from childhood up to adolescence that is supported by a strong family history of neurodivergent disorders [13]. As in this patient, the presence of definitive ASD symptoms such as hyper-sensory sensitivity, social difficulties, and rigid routines is suggestive [13]. The environmental stressors had possibly exacerbated her ASD. Social anxiety or post-traumatic stress disorder can be ruled out since she did not have any anxiety symptoms, nor did she experience any flashbacks when in a social situation.

Involvement of a multi-disciplinary team, which included a pharmacist, a counsellor and a primary care physician, had contributed to the success of managing Miss A. School collaborative strategies and family involvement further facilitated the successful outcome. Addressing ACEs through supportive counselling and education for both the patient and her parents is crucial. Improving her coping skills, emotional regulation, and resilience had aided the healing process of her ACEs.

Selective serotonin reuptake inhibitors (SSRIs) are effective and safe in the treatment of childhood anxiety disorders and depression [1,11]. A low dose of sertraline 25mg at night and a short course of benzodiazepine were prescribed after parental consent. Miss A showed symptom improvement after a month of the medications. The dose was continued at the same level during the follow-up in order to minimize potential side effects. This pharmacological intervention had hastened her recovery.

Her recovery and prognosis are also being influenced by the presence of sustained social support from both parents and teachers. School refusal can be prevented through regular mental health check-ins, supportive school and home environments [11]. Engaging in open communication about the adolescent's mental health and school experience will foster a supportive atmosphere. As families, especially parents, start to understand the connection between anxiety and avoidance behaviours, they can be empowered to help children and adolescents thrive and boost resilience. Currently, Miss A and her family are becoming a focus of reference to other parents in terms of handling school refusal conflicts.

4. CONCLUSION

This case highlights the necessity of looking beyond behavioural issues and addressing the underlying cause. Primary care physicians play an essential role in identifying and managing children and adolescents with school refusal, including those who have experienced ACEs. A thorough history taking and a high index of suspicion are crucial in managing adolescents with complex psychological needs.

Moreover, school-based mental health initiatives should be created to be friendly to the students by promoting a good and supportive environment at school. Importantly, an individualized, multidisciplinary approach that includes healthcare providers, educators, family support, and peer networks is fundamental for effective management and long-term success in overcoming school refusal and its associated challenges.

5. ACKNOWLEDGEMENTS

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6. GENERATIVE A.I DISCLOSURE STATEMENT

AI was used to summarize the timeline of the chronological events (Figure 1).

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7. PATIENT'S CONSENT

Written informed consent for publication of this case report was obtained from the patient's parent/legal guardian. A copy of the written consent is available for review by the Editor upon request.

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9. CONFLICT OF INTEREST

Authors declare none.

10. AUTHORS CONTRIBUTIONS

Siti Umi Fairuz Azmi: clinical management, conceptualization, manuscript drafting and editing.
Zamrina Amat: clinical management, critically reviewed the manuscript.
Noor Azimah Muhammad: clinical supervision, conceptualization, critically reviewed the manuscript
Wan Salwina Wan Ismail: specialist consultation, critically reviewed the manuscript.
All authors read and approved the final version of the manuscript and agree to be accountable for all aspects of the work.

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