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ORIGINAL PAPER

School Absenteeism and Child Mental Health: A Mixed-Methods Study of Internalizing and Externalizing Symptoms

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Abstract

School absenteeism among children and adolescents has been associated with a myriad of adverse outcomes. Despite a substantial amount of research on school attendance, our understanding of absenteeism in elementary-aged children with mental health difficulties is limited. The current study used a mixed-method sequential explanatory design to gain a better understanding of the links between children's mental health symptoms, age, gender and school absenteeism. The study included two phases: Phase I presented a quantitative investigation of the links between absenteeism and mental health symptoms in a large sample ($N = 750$) of primarily White (74%) clinic-referred children aged 5–12 years. Phase II used a participant selection model and chart review design to garner a deeper understanding of how school absenteeism presents in children with mental health problems in the elementary years. Results suggested that internalizing symptoms were significantly related to school attendance problems, and this association worsens as children age and as internalizing symptoms increase in severity. Externalizing symptoms were associated with absenteeism as well, but these findings showed that school attendance problems were worse for younger children with low to moderate levels of externalizing symptoms. The qualitative chart review illustrates the complex interplay of school absenteeism and child mental health, particularly for children experiencing co-occurring internalizing and externalizing problems. Children often struggled academically and socially, with some exhibiting increasing levels of school refusal and truancy and others displaying aggressive behaviors resulting in suspensions. Future studies that examine additional contextual factors, such as school and family variables, with longitudinal cross-lagged models and diverse families are needed to develop a comprehensive understanding of causal associations and their impact on children's school attendance across children's development.

Keywords School absenteeism · School attendance problems · School non-attendance · Child mental health · Externalizing · Internalizing · Mixed methods · Elementary school · Chart review

School absenteeism has been declared a pressing and "universal" problem facing children, youth and school systems internationally (Fredriksson et al., 2023; Long & Danechi, 2023). This issue was magnified during the COVID-19 pandemic, when record numbers of students were physically absent from school, many of whom experienced increased mental health problems (Korczak et al., 2022). The detrimental impact of school absenteeism among children and adolescents is well-documented; it is associated with academic difficulties, impaired social-emotional development, and increased high-risk behaviors (Kearney & Albano, 2018). In addition, long-term adversities, such as school drop-out and barriers entering the workforce, are more likely for children who are chronically absent from school (Munkhaugen et al., 2017). Children who struggle with mental health difficulties are at a greater risk of absenteeism concurrently and over time (Gase et al., 2014; Gottfried et al.,

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2019; Lawrence et al., 2019; Panayiotou et al., 2021; Wood et al., 2012); however there remains a limited understanding of how absenteeism presents in children with mental health difficulties, particularly for children in the elementary grades. With the recent increases in mental health problems (Bussières et al., 2021) and school attendance problems (Attendance Works, 2021) among younger children, a deeper understanding of this problem is important and timely.

Problematic absenteeism is defined differently across countries and school communities, but generally refers to sustained absences from school that impose detrimental impacts on students. Four main categories of problematic absenteeism have emerged from the research and are corroborated by a growing body of empirical evidence: (a) school refusal (i.e., emotional/anxiety-driven absenteeism), (b) truancy (i.e., unexcused absences), (c) school withdrawal (i.e., parent-motivated absenteeism), and (d) school exclusion (i.e., school-motivated absenteeism; Heyne et al., 2019). In contrast, nonproblematic absenteeism typically refers to absences that are deemed legitimate by both parents/guardians and school administration (e.g., religious holidays, illness, appointments) and can be compensated for (e.g., through home-schooling, online education, make-up assignments; Heyne et al., 2019; Kearney, 2003). Although these absences are typically viewed as nondetrimental to students, some research suggests that absenteeism for any reason is proportionally related to poor outcomes. For example, Hancock and colleagues (2013) demonstrated that the average academic achievement of elementary and secondary students decreased with any level of absence, including both problematic and nonproblematic absences.

Research on the developmental trajectory of school absenteeism shows inconsistent findings. Some research shows that the risk of school absenteeism increases as students age (Skedgell & Kearney, 2018). For instance, Balfanz and Byrnes (2012) found that persistent absenteeism begins in the primary grades, tapers off in middle elementary school, and increases in high school. Neild et al. (2007) have posited that older students face increased academic and social demands, placing them at greater risk of absenteeism. In contrast, Ansari and Pianta (2019) found that rates of school attendance problems remain stable throughout the schooling years. It is important to note that children with higher absences during the early years of schooling, including kindergarten, are more likely to experience higher rates of absenteeism later on. This trend is observed both within the same academic year and across multiple grades (Ansari & Pianta, 2019; Gottried, 2017). These findings point to early school absenteeism as a developmental risk factor and highlight the need for understanding more about how child development is related to school attendance problems.

Literature regarding gender differences in school absenteeism rates displays mixed results as well. Although some research shows males students display lower attendance rates than female students (Klein et al., 2020; McCoy et al., 2007; Uppal et al., 2010; Wagner et al., 2004), other studies have also shown no gender differences regarding school absenteeism rates (Allen et al., 2018; Anderson & Romm, 2020; Henry, 2007; Ozkanal & Arikan, 2011; Rivers, 2000). Attwood and Croll (2006) suggested that although no significant association between gender and rate of truancy in secondary schools was found, a slight difference between males and females in truancy rates across time was displayed; as children age, truancy likelihood increased, such that females were less likely to truant than males during their early developmental years, while being more likely to truant as they age. Other research has found that the association between gender and school absenteeism rates depends on the presence of experienced victimization and behavioral issues. Female children experiencing peer victimization (directly: verbal or physical aggression; indirectly: social and relational aggression) were found to have higher rates of absenteeism due to internalizing symptoms and avoidance behavior following victimization experiences (Dorio et al., 2018; Gastic, 2008; Hawker & Boulton, 2000; Rigby, 2003); whereas, males were more likely to be absent (by suspension) due to externalizing problems (King & Ganotice, 2013; Losen & Skiba, 2010; Matthews et al., 2009; Yang et al., 2018). In addition, males who experienced peer victimization—but did not display externalizing behaviors—had better attendance rates than females who did experience peer victimization (Tan et al., 2017). These mixed findings underscore the complex interplay between children's gender, age, and mental health and emphasize the need for a more comprehensive understanding of these factors with respect to school absenteeism, particularly among younger children.

Indeed, a large research base supports the link between school absenteeism and child mental health. Emerging research suggests that dimensional transdiagnostic factors (i.e., the internalizing-externalizing model of mental health) account for the development and continuity of impairment over time and function as the primary links between disorders and outcomes (Eaton et al., 2015; Krueger & Eaton, 2015). It has been demonstrated that internalizing symptoms, such as anxiety (e.g., Finning et al., 2019a), mood disorders (e.g., Finning et al., 2019b; Gase et al., 2014), and trauma- and stress-related disorders (e.g., Stempel et al., 2017; Wherry & Marrs, 2008) are closely linked with school attendance problems in childhood. Behaviors commonly seen among children with internalizing issues include various forms of anxiety (i.e., general, social, and separation anxiety), depression, feelings of worry and fear, fatigue, somatic complaints, social withdrawal, and sleep problems (Fornander & Kearney, 2020). It is possible to imagine how such symptoms may hinder school attendance. For example, a student who worries about negative evaluations of their

peers may avoid school one day. However, their avoidance of school leads to further disengagement as their worry extends to what others may think of them upon their return, eventually leading to chronic absence from school.

Research also links attendance problems with externalizing issues, particularly those pertaining to disruptive behavior (Kearney & Albano, 2004; Lawrence et al., 2019). Common neurodevelopmental and impulse control diagnoses have been linked with attendance problems, including attention-deficit/hyperactivity disorder (ADHD; e.g., Kent et al., 2011), oppositional defiant disorder (ODD), and conduct disorder (CD; e.g., Egger et al., 2003; Lawrence et al., 2019; Wood et al., 2012). Behaviors commonly observed among children presenting with externalizing behaviors include physical and verbal aggression, temper tantrums, defiance, non-compliance, disruption, and antisocial behavior (Fornander & Kearney, 2020; Ingul et al., 2011).

Given the plethora of symptoms experienced by students with internalizing and/or externalizing needs, it is not surprising that they often face difficulties with academics as well as relationships with teachers and peers. However, schools can moderate this impact. School climate, in particular a students' sense of connectedness to their class or school, has been found to be significantly correlated with achievement, attendance and negatively correlated with peer victimization and drop-out (Havik & Ingul, 2021; Kearney, 2008). Understanding the ways in which students with mental health difficulties experience school attendance problems can inform prevention and intervention on the part of schools and other key partners.

Current Study

Despite the extant literature on this topic, our understanding of absenteeism in elementary-aged children with mental health difficulties remains limited. Both large-scale quantitative analyses that offer overarching trends and small-scale qualitative analyses that query the lived experiences of children with mental health difficulties are required to deepen our understanding of the associations between school attendance and child mental health.

To this end, the current study used a mixed-method sequential explanatory design (Ivankova et al., 2006) to gain a better understanding of the links between children's mental health symptoms, age, gender, and absenteeism. This design permits a fulsome investigation of these variables as it utilizes the collection and analysis of large-scale quantitative data, followed by a deeper qualitative analysis of clinical chart data to generate a more nuanced understanding. Using path analyses with multiple regression, Phase I of the study presents a quantitative investigation of the links between school absenteeism and mental health symptoms in a large sample of elementary-aged children seeking mental health services. Phase II uses a participant selection model (Ivankova et al., 2006) whereby the quantitative data from Phase I were used to identify and select participants for the in-depth chart reviews. A narrative analysis was then used to garner a deeper understanding of how school absenteeism presents in children with mental health problems in the elementary years. Both phases of the study employ a transdiagnostic approach to describing mental health difficulties by examining the broad factors of internalizing and externalizing behaviors, rather that discrete diagnostic categories.

Phase I

Method

Procedure

All procedures for this study received ethical approval from both the participating mental health treatment center and the university ethics board at the authors' institution. Participants were recruited over a two-year period between August of 2017 and July of 2019 at a public children's mental health agency (hereafter referred to as "the center") that serves children from birth to twelve years of age in a large city in Eastern Canada. Families visiting this center may be seeking services for a range of child mental health problems. During their first visit to the center, parents met with a clinician for a 90-min intake appointment.

The intake appointment is an in-person 90-min interview with the family (usually the parent/caregiver) to explore their needs and strengths in relation to the presenting concern. The intake assessment can end in one of three ways: (1) a resolution and discharge when the client's immediate concerns are resolved as strengths and resources are mobilized; (2) a referral when the client's concerns could be better met by an external agency; (3) an internal referral to services at the center. Where there is an internal referral, the following information is collected: demographic information, a psycho-social assessment (narrative), case notes, the Child and Adolescent Needs and Strengths Questionnaire, and the Strengths and Difficulties Questionnaire. For the purposes of our study, all school-aged children (aged 6 to 12) who were internally referred, and thus whose files contained demographic and rating scale data, were included in the study.

Participants

Participants were 750 school-aged children between the ages of 5 and 12 years with a mean age of 7.98 years ($SD = 1.96$). Approximately 16% of the sample had total family incomes of less than $60,000 ($n = 121$). Most of the sample was male

(64%, $n = 483$) and spoke English as their first language (93%, $n = 695$). Seventy-four percent of the sample self-reported as White ($n = 558$). Other participants identified mixed-race ($n = 39$), Black ($n = 22$), Latin American ($n = 5$), West Asian ($n = 3$), Southeast Asian ($n = 4$), South Asian ($n = 5$), Indigenous ($n = 8$), Chinese ($n = 5$), Arab ($n = 15$). Eighty-six participants preferred not to answer the question about racial ethnicity. Participants were asked to identify whether their child had been diagnosed with a mental/psychological disability prior to their intake appointment. Sixteen percent ($n = 120$) of the sample indicated that their child had a disability diagnosis (did not indicate the specific type of disability) which is in accordance with the young age of the sample.

Measures

Internalizing and Externalizing Symptoms. *The Strengths and Difficulties Questionnaire* (SDQ; Goodman, 1999) assesses mental, social, emotional, and behavioral functioning of children and youth from 4—17 years of age. Items are rated on a 3-point Likert scale completed by the parent/caregiver: 0 = *not true,* 1 = *somewhat true,* 2 = *certainly true*. For the present study, the SDQ *Behavioral Difficulties* subscale was used to assess externalizing problems (e.g., often fights with other children or bullies them; often lies or cheats), and the *Emotional Distress* subscale (e.g., many worries, often seems worried; often unhappy, down-hearted or tearful) was used to assess internalizing symptoms. The reliability and validity of the SDQ have been demonstrated in clinic and community samples across multiple countries, including Canada (e.g., Aitken et al., 2015; Marquis & Flynn, 2009; Stone et al., 2010; Woerner et al., 2004). Additionally, the SDQ has demonstrated adequate concurrent validity (Goodman, 1997, 1999; Stone et al., 2015), internal consistency ($\alpha = 0.83$ Total Difficulties, $\alpha = 0.80$ Impairment scores, $\alpha = 0.63$-0.77 Subscales; Bourdon et al., 2005), and test–retest reliability ($r = 0.71$ over an 8-week interval; Yao et al., 2009).

School Absenteeism. The *Child and Adolescent Needs and Strengths Scale* (CANS: Lyons et al., 2004) is a clinician-completed measure that assesses the strengths and needs of a child and their family. It is a communimetric tool (i.e., it is tailored to the specific characteristics and demands of the agency setting) and is intended for use in mental health settings. Each item is scored on a 4-point Likert scale by the clinician: 0 indicates *no evidence of a need*, 1 indicates watchful waiting/prevention, 2 indicates *action needed* (i.e., the need is interfering in child/youth/family's life in a notable way), and 3 indicating *immediate or intensive action is required* (i.e., dangerous or disabling levels of need). After or during the clinical intake interview, participating clinicians rated each child on the CANS school attendance subscale using the following descriptors, but in consideration of the level of need described previously: 0 = *no evidence of attendance problems, the child attends regularly*; 1 = *the child has some problems attending school, although he/she generally goes to school, he/she may have one or two excused absences per month*; 2 = *the child is currently having problems with school attendance, he/she may have one or two unexcused absences in a month*; or 3 = *The child is missing school on a weekly basis or more, whether excused or unexcused; includes those not attending school at all*. Previous research has shown that the CANS has concurrent validity (Alamdari & Kelber, 2016) and reliability at the item level (Lyons, 2009).

Analytic Plan

To examine the moderating effects of age between internalizing and externalizing symptoms and school absenteeism, ordinary least squares regression models were tested using the PROCESS macro for SPSS (v3.0; Hayes, 2018). This tool was selected as it automatically centers independent variables, creates interaction terms, and produces simple slopes for continuous moderator variables. PROCESS model 1 was used to test these simple moderations and simple slopes were examined at the mean and ± 1 *SD* for significant moderators.

Results

Preliminary Analyses

Means, standard deviations, and bivariate correlations for all variables are included in Table 1. Prior to including child gender and age as variables in the main analyses, their associations with levels of absenteeism were first examined. Child age was found to be significantly related to absenteeism ($r = 0.11$, $p \leq 0.01$), thus was included in subsequent analyses. Child gender was examined via an independent samples t test to determine if there were significant differences between male and female children in levels of absenteeism. This analysis revealed no significant gender differences ($t(735) = 0.14$, $p = 0.89$). As such, child gender was not included in the subsequent models. Path analyses using regression were conducted to explore associations between internalizing and externalizing symptoms and absenteeism in relation to child age.

Path Models

Model 1: Internalizing Symptoms and Age. We proposed a conditional effect of internalizing symptoms on school absenteeism dependent on child age. Results suggested that internalizing symptoms significantly predicted school

Table 1 Phase I descriptive data and bivariate correlations of path analyses variables

	M (*SD*)	Min	Max	Externalizing symptoms	Internalizing symptoms	School absenteeism	Child age
Externalizing symptoms	1.57 (0.74)	0	2.00	–	0.07*	0.55*	−0.74*
Internalizing symptoms	1.25 (0.61)	0	2.00		–	0.22**	0.32**
School absenteeism	0.30 (0.75)	0	3.00			–	0.11**
Child age	7.98 (1.96)	3	12				–

*$p \leq 0.05$, **$p \leq 0.01$

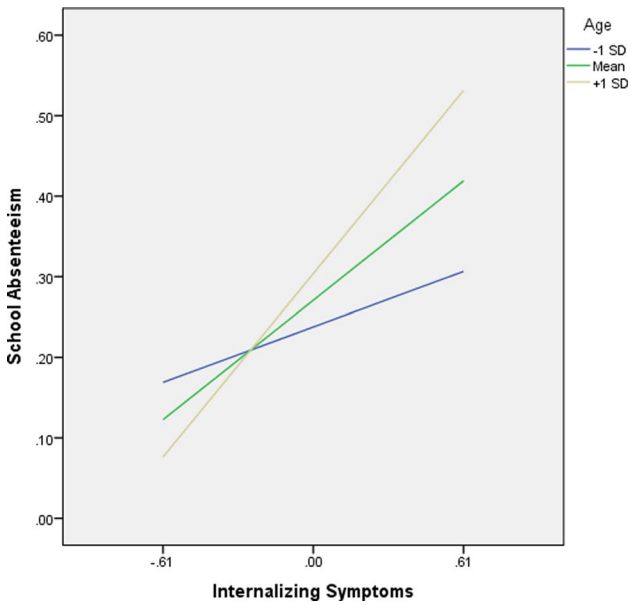

Fig. 1 Phase I Three-Way Interaction of Age Predicting School Absenteeism from Internalizing Symptoms

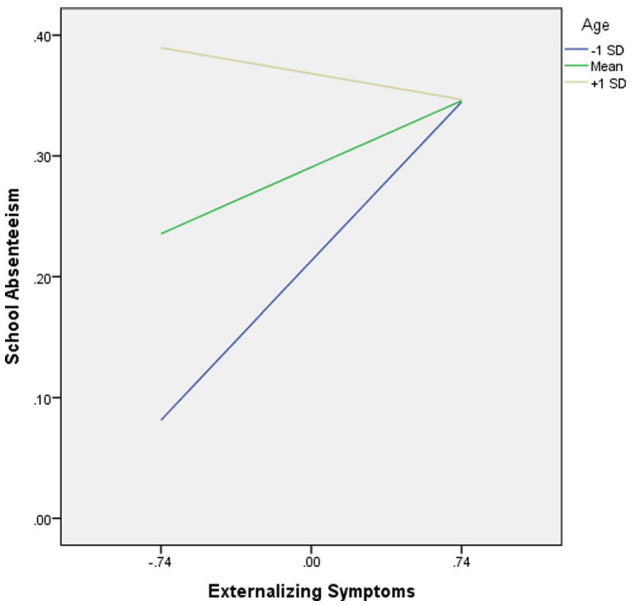

Fig. 2 Phase I Three-Way Interaction of Child Strengths when Predicting School Absenteeism from Externalizing Symptoms

absenteeism ($\beta = 0.24$, $t = 9.76$, $p < 0.001$). Age was not a significant moderator in the relationship between internalizing symptoms and school absenteeism ($\beta = 0.02$, $t = 0.01$, $p = 0.24$), however, the model was significant ($R^2 = 0.06$, $F(1,750) = 16.51$, $p < 0.001$).

To better interpret the nature of the moderated relationship between internalizing symptoms and school absenteeism, simple slopes were examined at the mean and ± 1 *SD* for age. Results suggested that the effect of age was significant for those with medium ($\beta = 0.24$, $t = 5.27$, $p < 0.001$) and high internalizing symptoms ($\beta = 0.37$, $t = 6.26$, $p < 0.001$). Figure 1 depicts the plotted simple slopes.

Model 2: Externalizing Symptoms and Age. We proposed a conditional effect of externalizing symptoms on school absenteeism dependent on child age. Results suggested that externalizing symptoms significantly predicted school absenteeism ($\beta = 0.80$, $t = 10.74$, $p < 0.05$). Age was a significant moderator in the relationship between externalizing symptoms and school absenteeism ($\beta = 0.04$, $t = 2.86$, $p < 0.01$) and there was a significant, negative interaction effect ($\beta = -0.05$, $t = -2.78$, $p < 0.01$). This model was significant ($R^2 = 0.03$, $F(1,750) = 6.38$, $p < 0.001$).

To better interpret the nature of the moderated relationship between externalizing symptoms and school absenteeism, simple slopes were examined at the mean and ± 1 *SD* for age. Results suggested that the effect of age was significant for those with low ($\beta = 0.08$, $t = 2.03$, $p < 0.01$) and medium externalizing symptoms ($\beta = -0.03$ $t = -0.58$, $p < 0.05$). Figure 2 depicts the plotted simple slopes.

Phase II

In line with the mixed-method sequential explanatory design (Ivankova et al., 2006), Phase II investigated school absenteeism and child mental health using a qualitative lens. Notwithstanding the well-established associations between child mental health problems and absenteeism (Maynard et al.,

2015), deeper explorations into the lived experiences of children struggling with school attendance and mental health difficulties are missing in the extant literature. Therefore, the aim of Phase II was to offer a deeper understanding of the interplay of school absenteeism and mental health problems and to provide examples from the lived experiences of children using a qualitative chart review.

Method

Participants

Participants were selected using criterion sampling. Using the total sample from Phase I, the clinical charts of children who received a clinician-rated score of moderate or severe school attendance problems (as indicated by a score of 2 or 3 on the CANS, see above for descriptions) were pulled, yielding a sample of 20 children. Of those, nine had sufficient data to proceed with clinical chart reviews (i.e., had no missing demographic or questionnaire data, and completed a full intake assessment with one of the center's staff members). The charts of five female and four male children (gender as reported by parents at intake) between the ages of six to twelve years ($M = 9.40$, $SD = 1.92$) were included. All children lived at home with their parents or guardians and spoke English as their mother tongue. All narrative data available in the participants' clinical charts were examined allowing for a longitudinal perspective of absenteeism challenges over the elementary years. Our qualitative sample size (nine participants) is justified in several ways (Vasileiou et al., 2018). First, we have pragmatic considerations, given the available data set and the specific focus on those participants who experienced significant school attendance issues. Only nine participants met our sampling requirements. The files of the nine participants were detailed, rich and lengthy, providing ample data for analysis. Finally, the goal of our qualitative phase was not to make broad generalizations or interpret the experiences of the nine participants as reflective of the population of students experiencing school attendance problems. Our analyses were exploratory in nature given the limited extant research.

Procedure

Phase II used retrospective chart review methodology (Sarkar & Seshadri, 2014). To be included, each chart must have included: (a) case notes completed by a clinician that provide detailed information regarding a child and the presenting concerns, (b) treatment plans completed by a clinician, (c) documents generated through the process of admitting/referring children to mental health services which typically included educational records, previous clinical and medical records, and other pertinent information, and (d) details in the chart about the child's history of internalizing and/or externalizing behaviors.

Data consisted of de-identified narrative summaries of information drawn from the client charts of the nine participants. To create the summaries, all documents in the participant charts were examined by supervised research volunteers (experienced graduate students in psychology or education) and any child or education-related information relevant to mental health and school attendance was included in the summaries. Before this process commenced, the volunteers were trained to use a "critical eye" to establish the meaning of the documents included within client charts and their contribution to the research questions being explored (Bowen, 2009). This involved initial and ongoing training and supervision on how to remain mindful of the nature, source, authenticity, accuracy, and purpose of each document. The primary researcher supervised the volunteer during the collection of the data to ensure the accuracy of data extraction. Disagreements between the primary researcher and volunteer were resolved through discussion.

Qualitative Analysis

The chart review of the nine participants consisted of a three-pronged analytic process. First, the de-identified summaries were read and re-read in order to develop a deep familiarity with the data. Second, key words, phrases, examples, and quotes that related to participants' internalizing and externalizing behaviors and their experiences with school absenteeism were extracted (Braun & Clarke, 2006). For example, key child and educational elements were extracted, such as mention of anxiety symptoms that prevented a child from attending school in a given capacity (e.g., parts of a day, whole days, weeks, months). Third, key contextual elements and examples were described among children presenting with internalizing behaviors, externalizing behaviors, or both, which enabled experiences to be explored and examples of participants' experiences to be described. This analysis provides a deeper, contextual understanding of the quantitative findings by drawing on participants' lived experiences (Ivankova et al., 2006).

Throughout the analysis process, dialog was held among the researchers and volunteers to discuss issues of reflexivity and to review the patterns and themes observed (Dodgson, 2019). The research team, consisting of individuals who share significant trust and partnership, brought insider and outsider perspectives to the school attendance problems described in the clinical files through their roles as parents, classroom teachers, counselors, psychologists, and educational researchers (Dwyer & Buckle, 2009). The ongoing discussions held throughout the analytic and interpretive process allowed for identification and challenging of biases. Independent analyses were conducted

by two of the team members prior to the collaborative process, thus providing investigator triangulation to promote credibility (Stahl & King, 2020).

Results

The qualitative results from the chart review are discussed in relation to the children's mental health difficulties (i.e., internalizing, externalizing, and both) and related school attendance problems. One child experienced primarily internalizing symptoms, three children presented with primarily externalizing symptoms, and five presented with co-occurring internalizing and externalizing difficulties.

Primarily Internalizing Symptoms

One female child was described as experiencing primarily internalizing symptoms, namely anxiety and depression, and first presented at the center at eight years of age. She was described as presenting with intermittent periods of absenteeism over a five-year period and experienced both school refusal and truancy. The female child's clinician reported that she had lagging skills in the areas of emotional control, social skills, and difficulty reading (although she excelled in other academic areas). It was mentioned multiple times in her chart that social situations often served as a trigger for her mood changes. For example, the child voiced to her clinician that she worried about upsetting her friends by not going to school. Peer conflict was also mentioned on multiple occasions, which contributed to her high levels of anxiety.

Despite reported efforts of this child's family and school to incentivize her attendance, this child missed 40 days of school within one school year, and there were significant periods of absences reported in following school years. As reported by the young female's father, she refused school "no matter what we do or try." This child would often become very distressed when having to get on the school bus or when entering the school building. If she did go to school, she would become defiant with her teachers and refuse to complete tasks. However, once she settled into her school routine, it was described that the child admired her teacher and enjoyed learning. Unfortunately, these positive feelings did not seem to foster more sustained attendance, and the child continued to present school refusal behaviors until her most recent visit to the center at the age of 12 years. In addition, truant behaviors were also demonstrated by the child across these years, which consisted of fleeing from the classroom and school property.

Primarily Externalizing Symptoms

The three children presenting primarily externalizing symptoms consisted of one female and two male children. The female child presented at the center multiple times between the ages of six and ten and experienced a host of behaviors along with diagnoses of both ADHD and ODD by 8 years of age. Behaviors referenced frequently in her chart included defiance, disruption, and physical aggression. No mention of learning difficulties was indicated. However, this child was described as experiencing significant social skill challenges and as both the perpetrator and victim of peer aggression, although there were no school-enforced absences noted in this child's chart.

Many similarities are reflected in the experiences of two male children regarding their presentation of externalizing symptoms and school absenteeism starting in the early years of elementary school. In particular, both male children were diagnosed with ADHD, demonstrated extensive histories of truancy and school exclusion, and presented with persistent and significant behavioral and emotional difficulties. Both males exhibited enduring aggression which interfered with their educational experiences, including verbal and physical aggression (e.g., violence, threatening with words and weapons, destruction of property). One male child voiced to his clinician that he did not trust school staff to keep him safe, and thus, felt compelled to use "physical force" as a means to do so. The other male child presented with aggression when situated in large groups and when expected to engage in activities that he was not interested in. As a result of their aggressive behavior, both children experienced school-initiated exclusionary practices throughout their schooling—one was expelled from preschool and the other was suspended in his early elementary years.

Regarding truant behaviors, both children were described as frequently fleeing from the classroom and school property and refusing to return. One male child was described as engaging in these behaviors to avoid schoolwork and school all together. It was explained by this child's teacher that the child would spend most of the day sitting under their desk or in the hallway. These behaviors persisted despite the multiple interventions that were put in place in an attempt to support this child, such as a behavior management plan, a half-day school schedule, working with an educational assistant, and attending multiple specialized education programs and classrooms.

Co-occurring Internalizing and Externalizing Symptoms

Of the charts reviewed, the majority of the participants presented with a combination of internalizing and externalizing behaviors. Together, there were five children between the ages of six and eleven in this category (three females, two

males) who experienced school refusal, truancy, and school exclusion. Most of these children presented with enduring and severe problems related to school attendance that started early in the children's schooling and persisted over several months and years.

Several notable internalizing symptoms were present in these children's charts. Suicidal ideation and self-harming behaviors were identified in over half of the charts, including one male child who also presented with clinical levels of low mood and enduring sleep problems. The teacher and psychologist of this particular child reported the presence of dark circles under his eyes on multiple occasions, as well as increased social isolation from peers and a disengagement from activities he previously enjoyed. Regarding externalizing behaviors, the majority of these participants presented with physical aggression toward a parent when being dropped off at school. Although some specific externalizing behaviors were reported toward a parent in this context, this group of children did not present with externalizing behaviors within the school environment, nor at home (only in the context of school drop off). Only one male child, who was diagnosed with ADHD when he was five years old, was described as having externalizing problems in the school environment. In particular, this child presented with behavioral difficulties when first arriving at school and having to separate from his mother. However, once he transitioned into the school day, he was described as making positive connections with peers and teachers and managing academic expectations.

Two male children had notable histories of very impairing internalizing and externalizing difficulties and demonstrated a myriad of attendance problems over the course of their educational journeys in elementary school, including school refusal, truancy, and school exclusion. The first male child was described as showing "uncontrollable anger", aggression, and "meltdowns" at home that could last up to two hours, all of which prevented attendance on a regular basis. Refusal and truant behaviors were often preceded by academic expectations that were perceived to be difficult by this child, as well as being told "no" by teachers. This child also received multiple suspensions for "unsafe behavior" at school, including several suspensions within a three-month period.

The second male child had symptoms of ADHD, a formal diagnosis of anxiety, and problematic relations with peers (i.e., getting "picked on" by peers, as reported by teacher and parents). Repeated notes in this child's chart discussed the anxiety experienced by this child in regard to failure, to which all clinicians and assessments indicated as a driving force behind his behavioral challenges. As noted by one clinician, the child experienced "school phobia" that contributed to a host of difficulties and chronic absenteeism. The verbally and physically aggressive behaviors demonstrated by this child also resulted in multiple suspensions, and necessitated support from a school social worker, one-to-one attention from an educational assistant, a significantly shortened school day (ranging from one to three hours a day over multiple school years), and attendance in multiple specialized education programs. Academic tasks were described as an area that brought about significant frustration, defiance, disruption, and truant behavior for this child, as well as suicidal ideation. One of his teachers claimed that this young child was academically capable, but "gives up too easily." From the child's perspective, as voiced to his teachers, parents and clinician, school was simply "too hard."

Integration and Discussion

The goal of this study was to investigate the interplay of mental health difficulties and school absenteeism among clinic-referred elementary school-aged children. Using a mixed-method sequential explanatory design (Ivankova et al., 2006), we first examined mental health behaviors and school attendance problems among a large sample of elementary-aged children using path analytic techniques. These results suggested that internalizing symptoms were significantly related to rates of absenteeism, and that this association worsened as children aged and as internalizing symptoms increased in severity. Externalizing symptoms were associated with absenteeism as well, but these findings showed that absenteeism rates were worse for younger children with low to moderate levels of externalizing symptoms. Child gender did not appear to impact these relations. To delve deeper into these findings, a subsequent qualitative chart review was conducted with nine children. These results pointedly illustrate the complex and devastating interaction of mental health difficulties and children's school absenteeism, particularly for those with co-occurring internalizing and externalizing challenges.

When examining the role of internalizing behaviors, both our quantitative and qualitative results demonstrated critical findings about its importance in school attendance among elementary-aged children. Our quantitative results revealed that in a large clinic-referred sample, as internalizing symptoms increased in children, so too did difficulties with school attendance. Importantly, for children with the highest levels of internalizing problems, school attendance appeared to worsen over development as children age, suggesting that internalizing problems in young children may pose a distinct risk for absenteeism. This trend was illustrated with our qualitative analysis, which examined the clinical chart of a young female child who presented primarily with internalizing behaviors. Her chart review revealed a notable history of increasing problems with anxiety, depression, and social problems. These difficulties seemed to be related to a long

history of school refusal behaviors, as well as truancy, which endured from age eight to twelve.

Increases in externalizing behaviors were also associated with higher rates of absenteeism in our quantitative sample, particularly for children with low to moderate levels of externalizing symptoms. For children with the highest levels of externalizing behaviors, school absenteeism was elevated regardless of their age. Our chart review illustrated the difficulties experienced by one female and two male children who had pre-existing diagnoses of ADHD and presented with notable aggressive behavior. These charts described common occurrences of physical and verbal aggression, and heavy involvement from school and support personnel. Of these children with externalizing problems, school exclusion, such as suspension or expulsion, and truancy, were commonly noted types of absenteeism in their charts.

The majority of the children in our chart review presented with both internalizing and externalizing problems. For these five children, serious and long-standing emotion dysregulation was noted throughout their charts and was related to several forms of school absenteeism. Much of their charts contained descriptions of serious problems with mood, sleep, self-harm, suicidal ideation, experiences of bullying, learning challenges, and social isolation. The severity and breadth of their problems was profound and illustrative of a great deal of personal suffering among these young children. These findings are in line with Sameroff's multiple risks model which posits that the greater number of risks present within and around a child, the more likely they are to experience negative developmental consequences (Evans et al., 2013; Gutman et al., 2003; Sameroff et al., 1998), including school attendance problems (Stempel et al., 2017). The findings from this study suggest that the presence of both internalizing *and* externalizing problems among young children may have a cumulative effect that is associated with a plethora of additional risks, including higher levels of school absenteeism, however further studies are needed to determine causal associations among these variables.

These results are supported by recent meta-analytic research which found large effect sizes for the associations between both internalizing and externalizing problems and absenteeism (Gubbels et al., 2019). However, most research on this topic to date has been quantitative in nature and conducted with adolescents; thus, our study provides a unique glimpse into the lived experiences of clinic-referred younger children. Despite our mixed-method design, it is important to note that our study has limitations. Importantly, our sample was primarily Caucasian (73%) and English-speaking (93%), and as such the results are not representative of the experiences of more diverse families. As highlighted by Kearney and Benoit (2022), marginalized children experience a plethora of systemic barriers that are inherently linked with school attendance, and the current study did not consider the experiences of underrepresented children. Second, we were limited to one broad measure of absenteeism, which may be why we did not see gender differences in our sample as previous research suggests that type of attendance problems may vary between males and females (Gastic, 2008; King & Ganotice, 2013). Improved measurement of school absenteeism is essential, and the recent development of a new tool, *The School Non-Attendance ChecKlist* (SNACK; Heyne et al., 2019), is promising in this regard. Research partnerships between researchers and school districts, who are responsible for tracking attendance for all students, are important to ensure the use of common measures that are sufficient and accurate for statistical record keeping, but that also inform effective interventions for students at-risk of school attendance problems.

Finally, we did not examine other potential contributing factors that are related to absenteeism and child mental health, such as school climate or family functioning, and the findings described in this study portray just a snapshot of associations between these variables in our sample. School absenteeism remains a widespread and far-reaching issue with reports calling school attendance problems a 'hidden educational crisis' (U.S. Department of Education, 2016), a problem that has been exacerbated in recent years due to the COVID-19 pandemic (Attendance Works, 2021). Future studies that examine additional contextual factors, such as school and family variables, longitudinally and with rigorous cross-lagged models, are critical if we are to develop a comprehensive understanding of causal associations and their impact on children's school attendance across different stages of children's development.

Taken together, the current study highlights the need for the use of multi-tiered systems (MTSS) of support to prevent and address school attendance problems. These models provide leveled interventions that account for contextual factors, including the child factors of internalizing and externalizing problems (Whitley et al., in press; Weist et al., 2018). Evidence surrounds the effectiveness of these models, such that schools who implement such approaches have less reported rates of school absenteeism (Freeman et al., 2016). Being aware of the internalizing and externalizing difficulties experienced by children are vital in providing such appropriate school-based prevention and intervention supports, thereby promoting positive school experiences.

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