Scandinavian Journal of Educational Research

ISSN: 0031-3831 (Print) 1470-1170 (Online) Journal homepage: www.tandfonline.com/journals/csje20

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To cite this article: Anne Kielland & Jing Liu (09 Jun 2026): School absenteeism and fear of school among Norwegian neurodivergent adolescents 13–17 years of age, Scandinavian Journal of Educational Research, DOI: 10.1080/00313831.2026.2685705

To link to this article: https://doi.org/10.1080/00313831.2026.2685705

SCANDINAVIAN JOURNAL OF EDUCATIONAL RESEARCH
https://doi.org/10.1080/00313831.2026.2685705

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School absenteeism and fear of school among Norwegian neurodivergent adolescents 13–17 years of age

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ABSTRACT

Neurodivergent children have a disproportionately high rate of *involuntary school absenteeism (ISA)*, understood not as truancy but as the inability to attend. This study explored how child-related, family-related, and school-related factors were associated with ISA in 274 adolescents diagnosed with attention-deficit/hyperactivity disorder, autism, and Tourette syndrome. Research on ISA rarely consults children, contributing to epistemic/testimonial injustice. We complement children's perspectives with parents' reports. In addition to ISA experiences, reported outcomes include dropout, current full-time school attendance, and school-related fear. ISA rates were similar across diagnoses. We therefore relate observed outcomes to shared divergence from an increasingly narrower child norm, and that this supports treating the group collectively for the analysis. Parents' socioeconomic characteristics were not associated with ISA, but school-related factors generally were. Friends at school, caring teachers, and academic mastery were associated with positive outcomes. Standard advice and interventions provided for ISA may be inadequate for neurodivergent children.

ARTICLE HISTORY
Received 2 December 2025
Accepted 22 May 2026

KEYWORDS
Neurodiversity; autism; ADHD; Tourette syndrome; school absenteeism; school refusal; school avoidance

Introduction

Neurodevelopmental diagnoses for autism, Tourette syndrome, and attention-deficit/hyperactivity disorder (ADHD) are on the rise across Europe, including in Norway (FHI, 2025). Simultaneously, scholars are giving increased attention to the presumed rise in what Pilkington and Piersel (1991) once coined as *school refusal* ("a normal avoidance reaction to an unpleasant, unsatisfying, or even hostile environment"), challenging older theories of absenteeism as *school phobia*. Following current norms for bias-free language (American Psychological Association, 2021, para. 5.4), this article refers to the phenomenon as *involuntary school absenteeism (ISA)* because this term currently appears most acceptable to the families concerned and has increasingly been adopted into the Norwegian discourse. Steers and Rhodes (1978) originally introduced the distinction between voluntary and involuntary absenteeism to differentiate employment absenteeism stemming from a lack of ability rather than from a lack of motivation to attend. This framework was later adopted in educational research as a key approach for understanding the underlying causes of school non-attendance (Birioukov, 2016). The term *school refusal* may imply a deliberate decision not to attend school; however, the ISA framework emphasizes that children are not merely avoiding unpleasant

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Supplemental data for this article can be accessed online at https://doi.org/10.1080/00313831.2026.2685705.

experiences. Instead they are attempting to protect themselves from harm. School refusal overlaps conceptually with *school phobia* in its emphasis on anxiety as a central explanatory mechanism (Di Vincenzo et al., 2024). Whereas anxiety and phobia are diagnostic constructs typically used to describe irrational emotions, the ISA framework conceptualizes school non-attendance as a rational act of self-preservation (Birioukov, 2016).

One survey of parents of children in ISA situations suggested that 40% had known neurodevelopmental diagnoses (Amundsen et al., 2022). Another study found that 50% to 53% of autistic children struggle to attend school (Munkhaugen et al., 2017). Respectively, in a Danish and a Swedish study, 45% and 56% of autistic children were in ISA situations (Autism and Asperger Association, 2022; Autism Association DK, 2023). Totsika et al.'s (2020) detailed study found "persistent non-attendance" in 43% of the 486 autistic U.K. students they surveyed.

By protocol, neurodevelopmental diagnoses are rarely given when a child appears to master regular everyday expectations, but referrals and diagnoses increase when school attendance becomes challenging (Chapman, 2023; FHI, 2025). Diagnoses are more often given to children born late in the year, illustrating how diagnosing reflects the mismatch between individual capabilities and school expectations beyond mere biology (Karlstad et al., 2017). It is reasonable to assume that children's perceptions of safety and well-being parallel how their predispositions match structural expectations in school.

Context: Norwegian education sector reforms

Recent Norwegian school reforms align with the increasing number of neurodevelopmental diagnoses (Nygård & Bjordal, 2024). Over the past 20 years, and with increasing intensity, Norwegian government whitepapers have stressed the need for children to acquire "self-regulation" skills. One defined "learning strategy" as

> the ability to organize and regulate one's own learning, be able to use time effectively, be able to solve problems, plan, implement, evaluate, reflect and acquire new insight and knowledge, and be able to adapt and apply this in new situations in education, work, and leisure. (Regjeringen, 2003, p. 36; author's translation)

Another whitepaper emphasized the capability to be flexible and develop "well-functioning social relations" (Regjeringen, 2009, p. 134; author's translation). In 2015, yet another defined self-regulation as "the ability to manage and take control of one's own actions, feelings, and thinking. Being able to work purposefully, resist distractions, and adapt in interaction with others" (Regjeringen, 2015, p. 20; author's translation).

The 2019 whitepaper mentioned *self-regulation*, the capability to "regulate attention, activity, impulses, feelings, and social conduct" (Regjeringen, 2019, p. 81; author's translation), 63 times. These whitepapers argued that self-regulation explains why girls outperform boys in school: They brought autism into the argument, referring to Baron-Cohen's (2022) controversial "extreme male brain" theory. Kristian Øen (2022) of the University of Bergen underscored that these whitepaper ideals pinpoint areas where neurodivergent students struggle disproportionately in contrast to their experiences in traditional, more tightly structured schools. The 2024 whitepaper, "A More Practical School," mentioned self-regulation only once – but emphasized responsibilizing children for their presumed "lowered endurance" (Regjeringen, 2024, p. 30; author's translation):

> When students experience stress and discomfort in meeting the school's demands and expectations, the school must not reduce its demands but teach children and young people to handle situations they will face for the rest of their lives. (p. 12)

Furthermore, it stated that the school should strengthen its work on "social and emotional competencies" (p. 72) and "teach pupils specific strategies, for example, to become better at controlling their own behavior and emotions in the face of challenging situations" (p. 71). Box 6.1. (p. 72) promoted one such program to enhance the new key terms, *robustness* and *resilience*.

Education sector reforms and neurodiversity

Neurodivergent brains are structured differently (Hashem et al., 2020; Yu et al., 2023). Observed synaptic underpruning might help explain their heightened susceptibility to stressors, such as sensory input (de Silva, 2018). In their book *The School Refusal Mystery*, Madsen and Brochmann (2022) outlined how students' stress levels increase as schools have become larger. Schools take up more of the children's time, have constant expectations for student participation, and, pedagogically and architecturally, provide fewer spaces to retreat and recharge. These new stressors may disproportionally affect neurodivergent students. They may jeopardize the students' social and academic mastery and challenge their safety, mental health, and well-being as their predispositions decreasingly allow them to meet new expectations.

Neurodivergent advantages, like hyperfocused learning and thriving in predictable contexts, become more difficult to access in stressful surroundings, narrowing the scope of "normality." As Chapman (2023) described, success then depends on characteristics that, to a lessening extent, overlap the strengths found in neurodivergence. The most recent Norwegian government whitepaper highlighted the emerging issue of school absenteeism. However, it only once mentioned autism and Tourette syndrome (but not ADHD), adding that these diagnoses appear overrepresented among those absent (Regjeringen, 2024, p. 26).

It is unclear whether general policy recommendations on school absenteeism are intended to apply equally to neurodivergent students. Ambitions to train children to self-regulate and become more "robust" may disregard cognitive structural differences in the neurodivergent brain and are not matched by similar strategies to unlearn other physical functional variations (Regjeringen, 2019, pp. 79–80). An underlying assumption may be that a "more practical school" will be more suitable for children with ISA. It may be for some. However, other neurodivergent children are more predisposed to theoretical studies and face social and structural – rather than academic – obstacles in school (Gelbar et al., 2022).

Ambition: school absenteeism and neurodivergence

This article aims to shed new light on factors associated with ISA among neurodivergent students. A close examination of empirical data from this population may help build an understanding of the mechanisms of their absenteeism situation. It could contribute to a critical assessment of their place in new strategies addressing a phenomenon where they are disproportionally represented – and the relevance of these strategies for neurodivergent children, their families, and schools. Due to considerable overlap between the three diagnostic groups (autism, ADHD, and Tourette syndrome) and internal variations within each group, this article treats the children as one group, assuming divergence from a norm to be a shared concern in ISA. Individual diagnoses are included in analyses when potentially relevant.

Under the Norwegian Education Act (Lovdata, 2024) §2-2, children have both a legal right and an obligation to obtain basic education. They are further granted the right to facilitation relative to their needs (§11-1–11-14) and a "safe and good psychosocial school environment" (§12-2). The type of school absenteeism discussed in this article is considered *involuntary* and, therefore, not in breach of §2-2. Rather, it is understood to be a consequence of the school owner's (municipalities) breach of §12-2 and §11.

Choice of terminology

The term *involuntary* acknowledges the distinction between children who *will not* go to school (truant) and those who, for legitimate reasons, *cannot* (Amundsen & Grøgaard, 2023; Madsen & Brochmann, 2022). The bureaucratic distinction between children with "legitimate" cause for absence, understood as medically authorized sick leave, and those "illegitimately" absent is

challenging among neurodivergent students. They have diagnoses, but those diagnoses do not authorize school absence. Nevertheless, their diagnostic features, combined with exposure to a school system developed for neurotypical students, generate stress that may trigger or strengthen expressions of somatic illness (e.g., stomachache, headache, bodily pain) and mental health challenges (e.g., anxiety, depression, eating and sleeping disorders; Botha & Frost, 2020). Notably, in their detailed study of 486 autistic students, Totsika et al. (2020) concluded that actual truancy was "almost non-existent." Therefore, the ISAs referred to in this article include most registered high absences, a choice further empirically justified by evaluating parent descriptions of the causes.

The annual school-based survey in Norway, Ungdata, documented that a decreasing share of Norwegian children *thrive* in school and an increasing share *fear* ("dread") going there (Bakken, 2024). This is a reminder that presence at school does not guarantee learning. Chronically frightened and alert children will struggle to learn socially and academically, and negative stress may worsen other physical and mental health issues (Botha & Frost, 2020). Returning to full-time school does not necessarily indicate "improvement" in the child's life. Therefore, for analytical purposes, this article also shifts its focus from attendance to identifying factors associated with children's school-related fear (SRF).

We use the increasingly popularized term, *neurodivergent*, to jointly describe the group of adolescents with diagnoses of autism, ADHD, and Tourette syndrome. Following the American Psychological Association's (APA, 2021, para. 5.4) recommendations, we asked young adults participating in the same survey if they identified with the concept of *neurodiversity*. In all three groups, most respondents replied *yes* or *uncertain*. Only 15% said *no*. We consider that this legitimizes the use of the term as bias-free language according to the APA.

The research question

Despite poor statistics, the discourse on school absenteeism assumes that ISA is a relatively new and growing phenomenon. Madsen and Brochmann (2022) asked, if school refusal were the answer to change, what factors constitute the equation? These factors are found in three primary areas, and their relative importance divides the ISA debate: (a) the child's characteristics, (b) their family's features, and (c) school-related conditions (Marswall et al., 2023). Corresponding to the first area, the medical field highlights neurodivergence-related ISA in terms of child pathology. Associated with a more bio-psycho-social approach, parts of the psychology and pedagogic disciplines extend the focus to the second area, the child's family and home conditions (Havik & Ingul, 2021; Johnsen et al., 2024). A broader sociopsychological approach suggests that structural changes in the third area, the school system, may be the most effective – or, at least, most practically viable – way to address ISA problems (Amundsen et al., 2022; Madsen & Brochmann, 2022). Our exploratory study investigates the association between school-related outcomes and a selection of related indicators within each of the three domains.

We ask: How are child, family, and school characteristics associated with ISA experience, SRF, and current attendance status?

Materials and methods

Although often studied, neurodivergent children are less frequently consulted about their perspectives, contributing to testimonial injustice and exacerbating the overall epistemological injustice experienced by the neurodivergent population (Chapman & Carel, 2022). However, children should not be stressed by lengthy questionnaires when mere facts can be obtained elsewhere. For this purpose, parents are valuable sources of complementary information. The online survey used for this analysis asked parents to provide background information and send a link to a shorter questionnaire to their neurodivergent children (aged 13–17 years), allowing the children to convey their own opinions, concerns, and perceptions. The survey included questions about school absence,

presumed causes, and three sets of factors hypothesized to be associated with the phenomenon. Of the 831 neurodivergent children eligible through links to the 738 completed parent questionnaires, 274 (33%) child-and-parent dyads completed both online questionnaires.

Analytical strategy

We took an exploratory approach using logistic regression to examine the associations between school attendance indicators and factors across child, school, and family domains because the outcomes and most factors were binary. Sex and age were included as control variables in all estimates, given their known influence on school attendance (which was also reflected in our data) and could otherwise have confounded the observed relationships. To simplify the exploration of correlations, we treated ranked variables (with five or eleven levels) as scale variables. For practical reasons, we primarily discuss statistically significant results in this article, although patterns of nonsignificant associations are equally informative (the supplementary files provide all analyses).

Measures

Outcome variables

The survey questionnaires (included in the supplementary files) combined standardized survey questions with innovative, analytically applicable questions refined in consultations with neurodivergent youth and their parents. Five key questions helped address the four main concerns related to ISA: asking the parents *whether* and *why*, in their opinion, their neurodivergent child had one or more periods of high school absence; asking the children if they were *now* attending school (*full-time*, *part-time*, or *not at all*); and asking the children if they were afraid of going to school (*often*, *sometimes*, or *not at all*) in *the past* and *currently*. Responses to these questions helped construct four main dummy variables: *ISA*, *dropout*, *current full-time school attendance*, and *SRF*. The ISA framework was operationalized as parents replying "yes" to the question "Would you say the child has or has had periods with high school absence?" and concluding that few of the explanations they added resembled truancy. The three categories of variables assumed to be relevant for exploring ISA included features of *the child*, *the family*, and *the school*. In all three indicator groups, we combined input from the child and parent questionnaires.

Child variables

In these main estimates, we examined the statistical associations between each type of neurodivergence (autism, Tourette syndrome, ADHD), the number of neurodevelopmental diagnoses, and whether the child had any additional diagnoses. We included the age at which the parents had first suspected a neurodevelopmental condition and the age of the first diagnosis.

Parent variables

We based most parent indicators on standard Statistics Norway questions about marital status, education, job situation, and three wealth indicators (household annual income, capability to manage a certain unexpected expense without a loan, and home ownership). We also asked the parents if one or both also had a neurodevelopmental diagnosis.

School variables

In the *school* module, we presented five claims to the children about the school situation – concerning teachers, peer students, friends, and academic mastery – and asked for their grades in Norwegian, Mathematics, and English.

Health and well-Being variables

To further study the life situations of the children and parents we adopted the method used by Statistics Norway, which builds on the World Happiness Reports and the Organisation for Economic Co-Operation and Development and U.S. practices (Marquez et al., 2024; Nes et al., 2018; Norwegian Directorate of Health, 2016). We included well-being assessments along cognitive, affective, and eudaimonic dimensions (Marquez et al., 2024; Nes et al., 2018).

Cognitive well-being was assessed by the standard question, "Overall, how satisfied are you with your life nowadays?" (on a scale from 0 to 10). We used a standard algorithm for estimating *affective well-being* as an overweight of positive feelings.[1] For the eudaimonic indicators, we used 0-to-10 scales for *meaning* ("To what extent do you feel that what you do in life is meaningful?") and *future optimism* ("Overall, how satisfied do you think you will be with your life 5 years from now?"). We included the responding parents' cognitive well-being and self-rated health.

Bias

An open survey will inevitably involve bias. However, the survey's stated objective was to study the well-being of neurodivergent youth and their families, not specifically ISA. This broader focus should reduce recruitment bias related to topic interest in ISA. We collaborated with the four leading interest organizations for recruitment.[2] We also encouraged participants to recruit others eligible within their networks by assigning links they could send directly to their contacts, thus reducing bias from individuals who were most active online. Self-selection in further recruiting these parents' children may also add bias. The parent-reported descriptions of the eligible children allowed us to compare the features of children who responded to those who did not.

Process

In the online questionnaire, we paid particular attention to the graphic interface. Getting neurodivergent children to complete a questionnaire poses group-specific challenges, including capturing their interest and attention and making answering the questions meaningful to them and worthy of their time and capacity. A public relations agency (KnowIt) and an IT company (Walr) were involved in optimizing the graphical and functional design of the children's questionnaire. The public relations company led the testing of the questionnaire with the research team as observers. The panel testing and feedback from neurodivergent children suggested ways to make participation more appealing through improved interface design and content relevance. We edited the content and design accordingly. A special challenge was to prevent participants from getting "stuck" on questions that were ambiguous or did not include options for all possible realities they represented. We offered participants incentives to complete the questionnaire, in the form of lottery tickets for electronic products, and their feedback later confirmed that these incentives had helped their motivation.

Ethics

The Norwegian Agency for Shared Services in Education and Research (SIKT) provided ethical guidance for the project. Bias-free language, especially concerning the use of identity-first language (IFL) versus person-first language (PFL), was carefully aligned with the APA (2021, para. 5.4) recommendations. Following these recommendations, we asked young adult participants in the same

[1]We used the average scores (0–10) for the feelings happy, engaged, calm/relaxed, and focused as positive feelings, and worried, anxious, down/sad, irritated, and stressed as negative feelings, subtracted the score for negative feelings from the score for positive feelings, estimated average score for feelings and calculated the share with an overweight of positive feelings (Nes et al., 2018).

[2]ADHD Norge, Norsk Tourette Forening, Autismeforeningen, and Nevromangfold Norge.

survey about their preferences. Slightly more autistic participants preferred IFL, whereas participants with ADHD and Tourette preferred PFL. Participants were informed in accordance with SIKT specifications, provided links to additional information on the project's web pages, and given a contact email. They gave informed consent electronically. No data that could identify participants were collected or recorded, and the survey was anonymous.

Results

Descriptives

The responding children were similar to the total eligible in age, gender, and diagnostic distributions, suggesting that only limited sample bias would stem from parent-to-child recruitment. Among the 274 responding children, 109 identified as girls, 157 as boys, and 8 as nonbinary. The mean age was 14.5 years (SD = 1,478); 191 (70%) had an ADHD diagnosis, 112 (41%) an autism diagnosis, and 60 (22%) had a Tourette syndrome diagnosis, corresponding fairly proportionately to the relative prevalence in the child population (3.6% with ADHD, 0.9% with autism, and 0.46% with Tourette syndrome diagnoses by age 12 years) (Surén et al., 2018; Surén, Bakken, et al., 2019; Surén, Havdahl, et al., 2019).

Among children with periods of high absence, one in five had dropped out. When asked why their children quit school, most parents reported "school phobia/school refusal". Many cited missing facilitation relative to their needs. Within this article's defined approach, all the children qualified as being in an ISA situation because their responses implied that the lack of safety and facilitation had made schools inaccessible to them. This result supports Totsika et al.'s (2020) suggestion that truancy may be rare in this group.

According to the parents' responses, 54% of the children had experienced periods of elevated absenteeism. When asked why, almost 80% of the parents checked *school refusal*, *school phobia*, and/or *involuntary school absenteeism*. The remaining described other reasons, including mental and somatic conditions that appeared stress-induced (capacity problems, exhaustion, burnout, sleep problems, and head-, body-, and stomachache), bullying, humiliation, and lack of assistance. Based on the reports, it seemed reasonable to classify this entire group of children with elevated absenteeism as ISA because the learning they were entitled to have, in one way or another, had been made too physically and mentally costly to be realistically available.

Figure 1 shows that 149 of the 274 responding parents reported previous and/or current ISA situations. At the time of the survey, 31 of the ISA children had dropped out, and 51 reported they were now attending school full-time, 56 that they were attending part-time, and 11 that they were currently not attending.

Almost half (128) of the neurodivergent children described periods when they *often* "dreaded" going to school. Another third (97) reported periods when they had been *sometimes* scared (SRF).

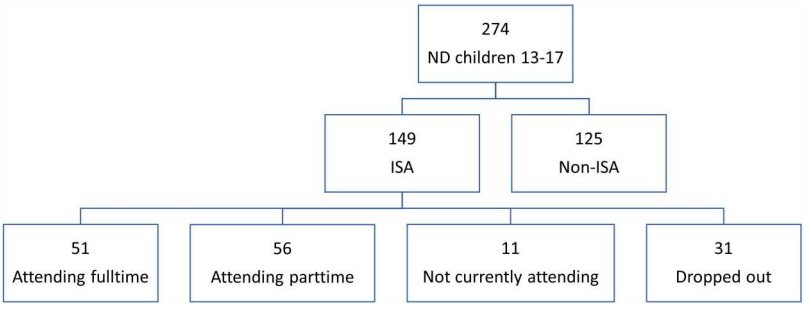

Figure 1. Outcomes of involuntary school absenteeism (ISA) in a sample of neurodivergent (ND) children 13–17 years old (N = 274).
Note: ISA = involuntary school absence; ND = neurodivergence.

After removing the group that had dropped out, 50 reported being *often* scared, and 79 being *sometimes* scared to go to school at the time of the survey. Among the children still *often* scared, 15 were attending school full-time and 25 were attending part-time.

Statistical associations

Gender identity and age were statistically associated with the four outcome indicators and several of the independent variables used in the analysis. Table 1 presents outputs from a logistic model, controlling for background indicators of age and gender identity, in examining the statistical associations between the four school-related outcome variables and features of the child, the parents, and the school.

Children

First, ISA and SRF were equally likely in the three diagnostic groups. However, autistic children had a higher probability of dropping out and a lower probability of CSA. Having multiple neurodevelopmental diagnoses was negatively associated with CSA, while having additional diagnoses, mainly psychiatric ones, correlated positively with both ISA and SRF. Late suspicion of neurodivergence was negatively related to being full-time in school at the time of the survey, whereas late diagnosis was positively associated with SRF.

Parents

Strikingly, none of the parents' socioeconomic background characteristics were associated with any of the absenteeism indicators.

Schools

In stark contrast to the results on the parent indicators, all five school indicators were statistically associated with the outcomes and in expected directions. Positive evaluation of the teachers and other pupils was negatively associated with ISA, dropout, and SRF, and positively with being in

Table 1. Statistical associations (logit) between background features and Involuntary school absence, dropout, current full-time attendance (N = 274), and current fear of school (N = 235), controlling for age and gender identity.

		Parent-reported ISA (dummy)		Dropout (dummy)		Full-time school now (dummy)		Fear of going to school now (dummy)	
		B	Sig.	B	Sig.	B	Sig.	B	Sig.
Child	Autism (dummy)	0.349	0.180	0.822	0.042	−0.874	0.001	0.114	0.662
	Tourette (dummy)	0.325	0.297	−0.035	0.944	−0.165	0.590	0.369	0.245
	ADHD (dummy)	−0.358	0.201	−0.189	0.652	0.447	0.103	−0.023	0.935
	Number of ND diagnoses (1–3)	0.227	0.345	0.536	0.129	−0.619	0.015	0.304	0.217
	No other diagnoses (dummy)	−0.951	0.002	−0.908	0.156	0.616	0.052	−0.766	0.009
	Age parents suspected ND in child (0–16)	0.029	0.443	0.051	0.357	−0.108	0.005	0.050	0.201
	Age child diagnosed (0–17)	0.034	0.418	−0.024	0.705	−0.047	0.277	0.090	0.033
Parents	Parents married/cohabiting (dummy)	−0.147	0.635	0.339	0.498	−0.012	0.969	0.029	0.260
	Parent completed higher ed (dummy)	0.423	0.210	−0.741	0.128	−0.204	0.541	−0.207	0.551
	Parent works fulltime (dummy)	−0.382	0.154	0.307	0.475	0.167	0.529	−0.103	0.697
	Household annual income (1–5)	−0.191	0.298	0.152	0.597	−0.019	0.917	−0.193	0.298
	Unexpected expense (dummy)	−0.278	0.280	−0.376	0.361	−0.120	0.640	−0.221	0.392
	Homeownership (dummy)	0.324	0.445	−0.286	0.632	0.438	0.292	0.077	0.856
	Number of parents with ND diagnosis (0–2)	0.123	0.569	0.103	0.751	−0.024	0.911	0.034	0.877
School	Most of the teachers are nice (dummy)	−1.148	0.000	−2.126	0.001	0.770	0.004	−0.749	0.004
	At least one teacher who cares (dummy)	−0.880	0.001	−3.088	0.000	1.277	0.000	−0.976	0.001
	The other pupils are nice to me (dummy)	−0.732	0.005	−2.416	0.000	1.039	0.000	−1.204	0.000
	I have a best friend in school (dummy)	−1.254	0.000	−3.618	0.000	1.609	0.000	−1.081	0.000
	I feel I master academically (dummy)	−1.120	0.008	−2.922	0.005	0.692	0.113	−1.600	0.000

school full-time at the time of the survey. Own experience of academic mastery was negatively associated with ISA, dropout, and SRF. This result was further confirmed, especially by the grades in mathematics (ISA and being in school full-time) and Norwegian (SRF and being in school full-time). The mean grade in Norwegian, Mathematics, and English was statistically significant for all outcomes except dropout, and in the expected direction.

School-Related fear

We have argued that the children staying in school full-time is a less important outcome than them thriving there. Figure 2 illustrates that SRF can take three paths: dropout, living with the same SRF level, or experiencing a reduction in SRF. The overall impression is that age reduces fear; however, many dropouts are among those who previously reported high SRF levels. Among the 44 children who were *not scared* in the past, only one is scared now. Among those who were *sometimes scared* before, four dropped out, one is more scared, and 40 remain sometimes scared – but 48 are no longer scared to go to school. Among the 129 children who were *often scared*, 26 dropped out, 52 remained often scared, 39 were sometimes scared, and 12 were no longer scared to attend school.

Using medication at the time of the survey data was the only child-related factor associated with fear *reduction*. The only parental feature associated with fear reduction was the child having one or two neurodivergent parents. Among school-related factors, having at least one caring teacher was the only indicator that stood out as helpful.

Consequences for child and parental health and well-Being

Table 2 shows how the four outcomes were associated with child and parental health and well-being. All well-being indicators were associated with the schooling outcomes in undesirable ways, suggesting some downward-spiraling dynamics between well-being and ISA in the children and their parents. Additionally, the parent's rating of their child's health was associated with unwanted outcomes; even parental self-rated health was associated with ISA and dropout. A final factor should be mentioned: Medication is readily available to the group; after asking whether the child was currently on medication, we found no association with the ISA experience. However, we noted a positive association between medication and present school attendance and a negative association with SRF.

Discussion

More than half of the neurodivergent children in the sample had periods of ISA. A full 86% described periods with some or frequent SRF, underscoring the importance of enforcing

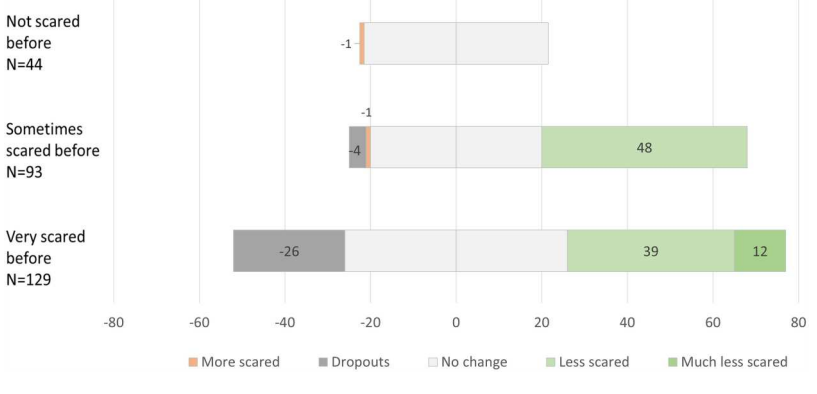

Figure 2. Changes over time in fear of going to school (Frequency).

Table 2. Statistical associations (logit) between Health and Wellbeing and Involuntary school absence, dropout, current full-time attendance (N = 274), and current fear of school (N = 235), controlling for age and gender identity.

	Parent-reported ISA (dummy)		Dropout (dummy)		Full-time school now (dummy)		Fear of going to school now (dummy)	
	B	Sig.	B	Sig.	B	Sig.	B	Sig.
Cognitive wellbeing (0–10)	−0.264	0.000	−0.138	0.131	0.261	0.000	−0.315	0.000
Affective wellbeing (overweight pos.) (dummy)	−1.143	0.000	−0.354	0.408	0.988	0.000	−0.996	0.000
Eudaimonic wellbeing (meaning) (0–10)	−0.204	0.001	−0.214	0.016	0.231	0.000	−0.269	0.000
Eudaimonic wellbeing (optimism) (0–10)	−0.123	0.047	−0.222	0.012	0.187	0.003	−0.207	0.002
Parents rating of child's health (1–5)	−0.820	0.000	−0.877	0.000	0.670	0.000	−0.572	0.000
Cognitive wellbeing parent (0–10)	−0.245	0.000	−0.100	0.295	0.224	0.000	−0.154	0.014
Parent-rated own health (1–5)	−0.404	0.006	−0.478	0.043	0.152	0.292	−0.217	0.133

Note. ND = neurodivergence.
Statistical Associations (Logistic) Between Health and Well-Being and Involuntary School Absence (ISA), Dropout, Current Full-Time Attendance ($N = 274$), and Current Fear of School ($N = 235$), Controlling for Age and Gender Identity
Note. $N = 266$. "Don't-know" answers were not included in the cross tabulations.

neurodivergent children's right to a safe and sound school environment. Previous research on ISA and neurodivergence, referenced in the Introduction, focused mainly on the autistic group, whereas this study also included children with ADHD and Tourette syndrome. Although ISA was slightly higher in the autistic and Tourette syndrome groups, the differences between those groups and the ADHD group were generally not statistically significant throughout the analyses. Having an autism diagnosis was associated with a higher probability of not attending school full-time at the time of the survey and of dropping out; however, autistic children did not have more SRF than the other groups. These results support the fruitfulness of understanding ISA challenges as largely shared within the neurodivergent population, despite clinical variations among the diagnoses and within-group diversity. Differentness, rather than diagnostic specificities, may represent the key challenge in our schools.

Relationships with parents

Unlike Totsika et al.'s (2020) research, our study did not find a statistical association between sociodemographic features (parent's marital, education, and labor status) and any ISA-related outcome. Similarly, in this population, we found no support for the Directorate of Education's general suggestion that family situation, poverty, low socioeconomic status, and low parental education among the parents influenced ISA-related outcomes (Marswall et al., 2023).

However, other parent-related factors were associated. Parental cognitive well-being and health correlated negatively with desirable outcomes. This could perhaps support an assumption that children are the "bearers of the parent's problems," as discussed by Madsen and Brochmann (2022). However, the underlying mechanisms are likely more complex. For instance, ISA may cause parental distress, add to, or enhance other existing stressors – disproportionally affecting parents of neurodivergent and other minority children (Jordal, 2023).

Second, it is plausible to assume negative dynamics between health and welfare and absenteeism-related outcomes. Poorer parental health and well-being may negatively affect a child's well-being and behavior – and, subsequently, the schooling outcomes shown in our findings. However, it is equally plausible that ISA children struggle due to how schools handle ISA and how the parents are expected to play a role in such handling. The Director of Education in Oslo has recommended that, for a child to thrive in school, "the adults" – parents and school staff – should "stand together" (Gerhardsen, 2024; Marswall et al., 2023). This statement triggered reactions in parent groups, who interpreted it as encouraging parents to support school staff in "teaming up" against the child and invalidating the negative school experiences they report.

On one social media outlet, parents repeatedly used the term, "gaslighting the children," in their comments (De Brysomme, 2024). Their reactions may have stemmed from the experience, like those documented by Jordal (2023), of parents receiving advice they do not consider helpful (e.g., to praise the school and pressure the child), but with which they nevertheless feel responsible to comply (Gudjonsson, 2017). Child and youth case worker Sara Eline Eide underscored that children in ISA situations

> feel that they have no adults on their team. They express that they are not heard and taken seriously. . . . We encourage the students to tell the adults if something is bothering them, but when they do, they are often met with statements such as, "No, you can do this," or "This is fine, you're so good." (Sundquist, 2020)

Inarguably, such generalized advice risks dismissing children's complaints as illegitimate or exaggerated. This may be particularly problematic for neurodivergent children, whose sensory systems are vulnerable to stress and overwhelm, and who may not yet fully understand that their preconditions diverge from those of their neurotypical peers. Practicing generalized advice may implicitly affect how neurodivergent children feel seen and understood.

Third, reflecting the dominating pathological model of ISA as phobic/anxiety-driven, the phenomenon is today often met with individualized explanatory models that understand features of the child (oversensitive) and their parents (overprotective) as the main problems to be addressed. Current policy documents, government media statements, school–parent dialogues, and prominent intervention programs reflect this position (Dagsavisen, 2024; Gudjonsson, 2017; Regjeringen, 2024; Utdanningsdirektoratet, 2025). Subsequently, extensive resources are invested in child psychiatric assessments and individual therapy, school-based individual assistance and special education support, and the child protection services had been contacted in half the families with ISA experiences in our sample. Currently a Danish transdiagnostic cognitive-behavior-therapy program is undergoing extensive Norwegian trials, despite failure to yield a statistically significant impact on its two primary outcome indicators in the Danish trial (Johnsen et al., 2024).

Training a neurodivergent child to "fit in" better and "toughen up" is challenging, without simultaneously triggering more masking of neurodivergent traits and reactions, even at home – especially when the children perceive their parents as being on the "adult team" (Rutledge & Botha, 2024). Movement functions as self-regulation in most neurodivergent children, and efforts to reduce stimming or movement may internalize stress and increase anxiety (Bernardin et al., 2021). Compliant children may mask or hide diagnostic traits to protect parents they see as struggling in ISA situations.

Two strategies at odds?

Two suggested back-to-school paths appear at odds with each other. Madsen and Brochmann (2022) described a situation where a child returned to school after finding "inner motivation". Such motivation may be encouraged by factors found to be statistically significant in our study, such as having a good friend at school, having nice teachers and students, or experiencing academic mastery. Similarly, exclusion and academic failure may discourage return (Amundsen et al., 2022; Amundsen & Grøgaard, 2023).

A return to school based on inner motivation, a process owned by the child, appears to be the most sustainable. However, developing inner motivation is a fragile process. Applying external pressure and manipulation or returning the child to a school situation where their right to a safe and sound learning environment with adequate facilitation is not ensured may jeopardize that process. Standard advice for ISA is founded on the notion that "absence yields more absence" and the claim that "every day counts," implicitly stressing the importance of a speedy return (Jordal, 2023; Utdanningsdirektoratet, 2025). Nevertheless, the empirical foundation for these essential claims remains unclear – as do the methodological approaches required to document their epistemic

validity beyond mere theory. An alternative theoretical model – based on patience, growth, and trust in the child's inner drive to learn and participate – is equally plausible, given an enabling environment.

Combining the two paths seems challenging because preventing absenteeism at all costs or stressing return is likely to be at odds with the more organic maturation process of cultivating new motivation from within. In a recent op-ed, two experts stated, "It is nevertheless presupposed that the school and workplace are experienced as safe and inclusive and give students and employees an experience of meaning and mastery" (Aftenbladet, 2024). However, ensuring these preconditions are in place appears to be underemphasized in the design of some intervention models currently pitched to school owners (municipalities), with individualized ISA solutions at their core (Johnsen et al., 2024; Regjeringen, 2024).

There is a drive to create universally applicable intervention models and reduce the inevitably high costs of individual-level interventions targeting a growing number of children in ISA situations. Providing an evidence base for such programs is, however, challenging, because the effectiveness of especially cognitive-behavioral-therapy-based approaches relies on participant maturation and motivation (Ben-Artzey, 2025; Crane et al., 2024). Due to international research ethical norms, such trials can only be conducted in a population that actively expresses consent to participate (World Medical Association, 1964). This will inevitably lead to non-trivial sample biases of concern for the cognitive mechanisms upon which the success of such interventions is based. Research ethics further call for particular caution in involving vulnerable groups like neurodivergent children in such trials, whereas results of studies on less vulnerable children cannot automatically be extrapolated to neurodivergent ones.

Early identification

This study's results support the notion that early identification of neurodivergence in children may be helpful (Vanaken et al., 2023). We found that the earlier parents recognize possible neurodivergence, the higher the likelihood that the child would be in school; the earlier the official diagnosis, the lower the likelihood of SRF. This is interesting because an opposite mechanism is also expected – that parents and professionals would identify children with more visible neurodivergent traits earlier, and that this group would be more likely to face disadvantages in school. To explain the complexity of this association, Madsen and Brochmann (2022) pointed out that many neurodivergent children are identified and diagnosed precisely *because* they experience ISA. This study's results appear to support the notion that children identified early can be more effectively acknowledged and accommodated in ways that uphold their well-being and learning in school, despite exposing more symptoms.

Mental health

Some studies have suggested that the internalizing difficulties often present in neurodivergence, rather than neurodivergence itself, become the main problem later in life (Andersen et al., 2023; Hovik, 2016; Orm et al., 2023). In the current study, more parents of children with ISA than without considered mental health issues to be the more significant challenge for their child. Whereas neurodivergence is congenital, some internalizing difficulties may be managed or prevented in an enabling environment where common neurodivergent vulnerabilities are recognized and respected. Inclusion of neurodivergent students in mainstream schools is a stated objective across the Scandinavian countries. However, a recent Swedish study suggested that inclusive practices may take time to become fully internalized among the majority of staff working with and around these students (Bölte et al., 2021).

Although not sufficient on its own, our results suggest that an enabling school environment is an essential part of the solution. Without an enabling environment in place, medication may be a last option – and studies on the long-term effects of types of medication offered to neurodivergent

children are not yet conclusive. Our study found no association between current medication use and ISA; however, medication was positively associated with current full-time attendance and negatively associated with SRF. Although the opportunity to receive help through medication is positive, given the status quo in our schools, we also need to ask: Does medication become a too-convenient substitute for investing in the enabling schools these children need to thrive and learn?

Concluding remarks

The downward spiral of ISA and mental health, learning loss, and later quality of life outcomes clearly deserves heightened awareness, as politicians are increasingly concerned about high absenteeism and increasing numbers of neurodivergent youth on disability benefits. Our study supports earlier research that showed highly prevalent ISA in the neurodivergent group and underscores that neurodivergent children in ISA situations suffer disproportionally in all well-being domains, as do their parents. They struggle with health issues, in addition to jeopardizing their future through learning deprivation.

The Education Act (Lovdata, 2024) may impose a duty on children to receive education, but legal duties are inseparably linked to legal rights. If school owners do not fulfill their obligation to provide neurodivergent children with a safe and sound school environment adapted to their learning styles and needs, one cannot legitimately argue that children must go to school and parents are obligated to ensure they get there. Acknowledging how cognitive variations in neurodivergence expose these children to overwhelm and unhealthy stress reactions suggests that common advice and recent education-sector strategies may be poorly adapted to a group that disproportionally dominates the ISA population today. The questions of what characterizes a school environment in which neurodivergent students can flourish, and how such environments can be created remain. Further research is needed to advance knowledge in this area.

Acknowledgements

We are grateful to Unge Funksjonshemmede [Disabled Youth Norway] for their support with the Dam Foundation grant, and Maiken Marie Jordal for support and helpful comments. The PR company KnowIt assisted with the graphical interface design and piloting of the survey, the IT company Walr with optimizing its functionality, and Donna Magnani with editing.

Disclosure statement

No potential conflict of interest was reported by the author(s).

Funding

This research was conducted under grants from the Dam Foundation (#353513) and the Research Council of Norway (#324591).

Ethical approval

The Norwegian Agency for Shared Services in Education and Research (#102670 and #928482). Bias-free language, especially the use of IFL, is aligned with the recommendations of APA (7th ed.), Section 5.4.

Informed consent

Participants were informed in accordance with SIKT standards, provided with a link to additional information on the project's web pages, and gave their consent electronically. No data that could identify participants was collected or recorded. The survey was anonymous.

Data availability statement

The primary data are uploaded to the SIKT repository and available at https://doi.org/10.18712/NSD-NSD3339-V1

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