

CALIFORNIA STATE UNIVERSITY, NORTHRIDGE

TARGETED INTERVENTION STRATEGIES FOR DIFFERENT ETIOLOGIES OF SCHOOL
REFUSAL BEHAVIOR: A TREATMENT MAP AND MANUAL

A graduate project submitted in partial fulfillment of the requirements

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School Psychology

By

Tonya April Claycomb

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The graduate project of Tonya April Claycomb is approved:

Doris Jones, Ph.D., Reader

Date

Joan Golden, Ph.D., Reader

Date

Wilda Laija-Rodriguez, Ph.D., Chair

Date

California State University, Northridge

Dedication

This dedication belongs, almost solely, to my dear husband and my loveable, gorgeous, funny, kind, amazing, smart, and very tolerant children. I thank all of you so much for supporting my endeavors to return to school and find a way to complete my long, twisted journey toward a proper college education.

Seth, Sage, and Jocelyn, in truth, you all probably deserve the degree more than I do. I love you all very much and I will forever be grateful for your support and love, and regretful for my lost time with you...sadly, I am very very regretful. This research paper and project, however, is most specifically dedicated to my eldest child, Seth, who will make his own path and design his own success.

Cliff, simply, thank you for EVERYTHING, you carried a big burden as I completed my last year and a half of graduate school. You increasingly played mom, dad, breadwinner, chef, and chief dish and bottle washer at home and in your business – I'm truly amazed and grateful. I guess your tit-for-tat debt is paid from when I supported you as you completed your university education. I suppose I have to start cooking dinner and doing laundry again, huh?

To my parents, Bob and Helen, I only keep discovering what amazing parents you are and were. I appreciate you now more than ever. Unlike my pie-in-the-sky childhood dream of parenting, where I imagined that I would be different than you in all kinds of positive ways, my grounded adult dream includes finding ways to be a lot more like you! I'm finding it difficult to rise to your level of parental accomplishment.

To my mom, Patty, I thank you for making it so obvious to me that you love me so much and you are so proud of me in my accomplishments.

To everybody else, my brothers and sisters and family at large, thanks for waiting for me while I read or wrote or avoided reading and writing. I acknowledge and appreciate how much you have minimized your true frustration, instead, demonstrating only minor irritation with my intrusive studies while in your presence. I know I've been a pain in the backside and I'm sorry; I have felt your support this whole time.

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ABSTRACT

TARGETED INTERVENTION STRATEGIES FOR DIFFERENT ETIOLOGIES OF
SCHOOL REFUSAL BEHAVIOR: A TREATMENT MAP AND MANUAL

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Tonya April Claycomb

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School Refusal behavior is on a continuum of behaviors that begin with excused absences under duress and end, at the most extreme, with school dropout. Short-term consequences include missing academic instruction that affects grades, missing opportunities to develop social skills with same age peers and non-familial adults, and increasing stress within the student's family. Long-term consequences from extended school refusal include academic failure, and dropping out of school. School dropout poses an enormous financial impact on both individual families, and society at large. Several systems influence when and why a student will demonstrate school refusal including family systems, school systems, the larger community, and the student's personal attributes. School based professionals can assist in identifying the etiology and function of school refusal in order to decrease risk for continued school refusal and reduce the likelihood for school dropout.

Chapter 1

Introduction

The profound impact of high school dropout is significant and well documented. In a culture and economy where a high school graduate finds limited career opportunity and diminishing income potential the drop out is at even greater risk. Dropping out is correlated with greater levels of incarceration, with many dropouts developing substance abuse problems, and many experiencing poor physical or mental health (Burt, 2002). What is less appreciated is that "dropping-out" is not just an isolated incident but also the culminating event on a continuum of behaviors broadly described as school refusal. It is in the early stages of school refusal when dropout intervention is most effective and cost efficient (Alexander, Entwisle, & Kabbani, 2001).

This is not to say that the deleterious effects of school refusal are limited to distal consequences such as poor peer relationships and family stress. From the onset, a student not in school for any reason misses instruction, which can cause immediate negative academic consequences leading to academic failure, and, potentially the dropping out of school all together. The old paradigm that school dropout as an event has given way to the realization that dropout is a process and the onus is global. School districts and administrators, teacher educators, and educational psychologists acknowledge that school dropout is a process where all parties share the blame and experience the consequences. The student, their peers, the family, the teacher, the class, the student body, the school district, state and federal governments, and society at large feel the effects of school refusal and therefore should be involved and invested in the prevention of school refusal and intervention as needed.

School refusal is defined by Kearney (2001) as any behavior where a child attempts to miss school or attends school under duress. It can include full or partial day absences and excessive tardies to one or more classes. Unfortunately, there is no consensus in schools, in districts, or in educational law that clarify the minimum days absent which may constitute school refusal behavior. In Addition, students who demonstrate school refusal behavior do it for varied reasons. Often school refusal is a manifestation of a child's anxiety or negative affect, whereas for other students it's a function of their desire to engage in other preferred activities, and often times, it's a combination of the two.

The real financial costs of school refusal, under the financial auspices of school mental health, are not as well understood as the costs of school dropout, which are well documented both qualitatively and quantitatively. Programs exist in local schools and communities, in broader reaching organizations and governmental agencies, to help reduce the growing number of school dropouts. However, few exist to help students when they begin to demonstrate school refusal behavior (Kearney, 2001). In Addition, few organizations exist to provide qualitative and quantitative information about students exhibiting school refusal behavior. If school dropout is the culmination, or end-point, of a process, it seems sensible and prudent to look at some of the catalysts or constructs which set this process into motion as a possible focus for prevention, or a starting point for intervention. One such catalyst evidenced is student mental health. Many students refusal school due to anxiety or in an effort to avoid negative affect associated with phobias or depression (Kearney, 2001).

According to the World Health Organization (2005), National Alliance on Mental Illness (n.d.), New York University Child Study Center (n.d.), and several researchers (Messer, Stangl, Farmer, Costello & Burns, 1998; Kearney, 2001; Wimmer, 2008), and

echoed in individual households everywhere, parents and families bear most of the burden associated with child and adolescent mental health issues. Children with mental health issues, just as with other medical conditions, often must miss school - leaving parent(s) with the burden of additional child care leading to their own missed work and poor performance that can lead to job loss and precipitating deeper family stress. This, in turn, can further exacerbate the child's mental health problems and enforce maladaptive behaviors that become part of their coping mechanism. The alternative, adolescents left on their own can, potentially, although not necessarily, facilitate delinquent activity (Sweeten, Bushway, & Paternoster, 2009).

Fortunately, there is mounting scientific evidence indicating cost efficiency of both mental health prevention and subsequent treatment intervention vis-à-vis the resulting increases in adult productivity (Henry, Bales, & Graves, 2007). Although quantitative cost-benefit analysis is problematic, it is reasonable to assume that costs will be reduced and productivity increased if impairment associated with mental health issues is assuaged. Beyond childhood, mental health disorders that plague adults, especially depression, anxiety, and conduct disorder, may have first been evidenced in school refusal behaviors (Kearney, 2001; Wimmer, 2008). Early intervention may preclude costly adult mental health services as well as lifelong unemployment or underemployment. Couple mental health issues with the failure to acquire a non-GED high school diploma and it becomes clear that the procession from school refusal to dropping out has significant impact not just on the individual and their family but their community and society as a whole (Stoep, Weiss, Kuo, Cheney, & Cohen, 2003).

Unlike the costs for school refusal, the costs for school dropout are well documented.

According to the National Center for Education Statistics (NCES) (2011), part of the federal Department of Education, in 2009, a total of 8.1% of students stop out of high school, however a disproportionate number of non-white students drop out before graduating. Specifically, 5.2% of white students, 9.3% of black students, 17.6% of Hispanic students, 3.4% of Asian/Pacific Islander students, and 13.2% of American Indian/Alaskan Native students drop out. These statistics show a downward trend in total dropouts since 1980 when the total percentage was 14.1%. It's important to note that different organizations, governmental and otherwise, dispute these statistics. For example, The Civil Rights Project at Harvard University and the Urban Institute in 2004 show that only 68% of students that enter 9th grade will graduate on time and with regular, non-GED diplomas. With regard to black, Native American, and Latino students, only 50% will graduate with a diploma and on time whereas 75% of white students will graduate with a diploma on time. Both organizations, The Civil Rights Project at Harvard and the Urban Institute, are examining the same statistics with an eye toward timely and typical graduation whereas the NCES is not. Lack of timely graduation and the difference between a non-traditional, general education equivalency diploma (GED) and a traditional high school graduation diploma make a financial impact on a graduate's life.

There is an invaluable predictive factor for high school graduation according to the National Education Association (NEA) (2006), socio-economic status. For example, students from families with incomes in the lowest 20% are six times as likely to drop out of school before graduating as students from families who have incomes in the top 20%. The absence of a high school diploma, or GED, is correlated positively with an increased risk for unemployment, underemployment, incarceration, and reliance on social welfare. According

to the Employment Policy Foundation (in National Education Association, 2006), the average yearly income for a high school graduate versus a non-graduate was approximately \$9,500.00 per year in 1995. It can be assumed that that yearly discrepancy has increased over time.

Indirect economic and non-racial factors, which are positively correlated with an increased likelihood that a student will drop out, can be found in examination of the student's family system. Factors such as structure (e.g. single family household), family stressors (e.g. death, divorce, or relocation), and parental unemployment or underemployment strongly influence graduation rates (National Education Association, 2006). These intra-family variables are also very likely to increase school refusal behaviors well in advance of any concerns with regard to high school graduation (Kearney & Silverman, 2006).

As one might expect, the performance of the individual student offers critical insight. According to the University of California at Santa Barbara's (UCSB) California Dropout Research Project, educational performance, student behaviors, student attitudes, and student background are all individual predictors associated with increased dropout risk (2008). In the area of educational performance, the researchers identified many factors which increase the likelihood that a student will dropout in the future, including low test scores and low grades in elementary school, middle school, and/or high school, with an especially strong correlation between grade retention and future dropout. In the area of student behaviors, the researchers identified a strong correlation between student engagements in school, both socially and academically, as demonstrated by increased time in school, low incidence of tardies and absences, lack of truancy, and involvement in clubs as inversely correlated with school dropout. In the area of student attitudes, a student's diminished belief that s/he can

achieve at school was positively correlated with school dropout, whereas a student's positive attitude toward individuals within the school (e.g. administrators, teachers) was inversely correlated with school dropout. With regard to the area of student background, student race and socio-economic status are predictive of school dropout. For example, Hispanics and African-American students dropout in higher numbers than Asian or Caucasian races, and student's with lower socio-economic status also dropout in higher numbers (UCSB, 2008).

There is a dearth of information relative to effective treatment models for school refusal behavior in students. Most of the research involves Universal, Tier 1 interventions at the district or school level, and those are often not well executed and existing resources are underutilized. Schools reserve Tier 2 interventions for students that demonstrate significant absences, although the number of absences that quantifies significant varies by school and district. In Addition, at most districts, typical Tier 2 or Tier 3 interventions employ a punitive model to illicit compliance in the area of attendance.

Statement of Need

Informal interviews with school psychologists and school counselors in the Los Angeles Unified School District (LAUSD), the Glendale Unified School District (GUSD), and the Pasadena Unified School District (PUSD) reveal varied and, often, discordant protocols in place to deal with pupil attendance, whether the attendance is related to student illness, family factors, or school refusal. The language used with regard to student attendance varies both within district and across districts. Terms such as truancy, school refusal, school anxiety, school avoidance, school phobia, and excessive absences were all used to point toward the same end product: problematic inattendance. This lack of consistent, common nomenclature relative to school refusal (e.g. school refusal, excessive absenteeism, school phobia, etc.) is a common theme in both research literature and the day-to-day activities of school professionals who may be in a position to intervene with students exhibiting this behavior (Kearney, 2003). The absence of a consistent and coherent nomenclature may be a contributing factor in both the lack of standardized, effective treatment for students, and in the evolution of more responsive school systems. School refusal is a broad term that covers any behavior where a child attempts to miss school successfully or non-successfully, or attends school under duress. School refusal can include full or partial day absences as well as excessive tardies to one or more classes. Often school refusal is a manifestation of a child's anxiety or negative affect, whereas for other students it's a function of their desire to engage in other preferred activities, and often times, it's a combination of the two. Many school districts within Southern California hire professionals for the purpose of handling student attendance issues. One such position, within Southern California school districts, is a specialized school counselor whose specific focus is student

attendance (the Pupil Services and Attendance (PSA) counselor); unfortunately, the job description, as posted on the LAUSD website, does not provide for counseling services for students or parents in order to mitigate of attendance problems. Instead, a PSA counselor is responsible for creating a comprehensive school wide attendance plan, taking daily attendance, clearing excused and unexcused absences, notifying parents and guardians of unexcused absences or trancies, and facilitating enrollment and check-out of students but only rarely is able to consult with the school psychologist regarding school refusal, school anxiety, or inattendance, not to mention those acts of truancy that may not be reported to the PSA counselor.

If the PSA counselor does not offer counseling to students, or to parents, when a student begins to demonstrate school refusal behavior, there are other professionals within schools, such as the school psychologist or the (non-PSA) school counselor who have the appropriate skill-set (counseling) and could offer services to school refusing students and their parents for the purpose of reducing absences. In Southern California districts, neither the school psychologist nor the school counselor is usually involved in offering interventions to school refusing students. If the PSA counselor, the school counselor, and the school psychologist are not assigned the responsibility to offer early, effective services to these students, then the student is likely to continue the behavior. Granted, sometimes the behavior remits spontaneously, but early, effective intervention is the gold standard for behavioral problems and psychological problems. In most Southern California school districts, school counselors are not present at elementary school sites, and in middle and high school, their primary responsibility is to attend to ensuring that students promote to the next grade and that students take the necessary classes to do so. School psychologists spend

most of their time focusing on special education assessments; however, the school psychologist may offer counseling to students who have DIS (designated instructional services) counseling services as part of their IEP (individualized education program). In Addition, DIS counseling is not typically offered as part of the IEP for the purpose of addressing school refusal behavior. PSA counselors are typically involved in offering Tier 1 interventions to the whole school; some of the interventions offered might be recognizing the class with the best attendance, and calling parents to request doctors notes after a predetermined amount of student absences has accrued.

Students who reach the threshold level of absences, excused or unexcused, will typically be referred to the Student Study Team (SST) within their school before they are referred to the School Attendance Review Board (SARB) within the state of California. SARB is the name California uses to refer to the team that works with parents, students, administrators, teachers, counselors, and social workers to address excessive student absenteeism which conflicts with compulsory school attendance; other states have their own version of this team named according to the department of education in that state.

Some schools or districts have a School Attendance Review Team (SART) for problem-solving attendance issues within the school, and may also have some pre-referral interventions in place. The California Department of Education (CDE) has a SARB review board where schools can be recommended for commendation with regard to their school attendance policy. The criteria for receiving commendation are broken down into ten content areas, the most important of which is area six which includes the prevention, early intervention, and intervention areas prior to SARB referral.

According to informal interviews conducted with individuals working in local school

districts, the CDE, and local school district literature, the SARB review represents an area of weakness. For example, the Ventura County SARB Manual (2004) suggests that early intervention steps are critical and often overlooked. These steps should be developed by the SST or SART team, which includes the school nurse, school psychologist, school counselor, administrator, parents and the student, and should target the causal reason for the absences in addition to providing both positive and negative reinforcements and punishments to encourage correction. Unfortunately, neither the CDE nor any local SARB policy available for online public viewing has a clear and specific protocol and treatment plan.

The Partnership for Families and Children (2004) has looked at effective truancy prevention models and discovered a set of criteria that they believe to be mandatory for intervention efficacy. These criteria include parent or guardian involvement, a continuum of services including incentives, consequences and targeted supports, collaboration with community resources including law enforcement, mental health, social services and mentoring, and school building components which ensure students have access to curriculum and ongoing evaluation.

The Wilder Research Center (2003) also reviewed the efficacy of several school refusal and truancy programs. Wilder's research agreed with the Partnership for Families and Children with regard to the necessary criteria for an effective truancy prevention program. In Addition, in a meta-analysis of existing research, Wilder Research found inconclusive evidence that incentives or rewards for attendance were effective, and that positive effects for peer group counseling were limited; however, research on group counseling was limited and based on small sample sizes. In fact, many research studies were deemed inconclusive due to the absence of a control group, or because of a limited

sample size (Wilder Research Group, 2003).

In scientific studies, the lack of a control group creates the potential for spurious results or inconclusive correlations relative to the treatment plan; however, when working with troubled parents and students in need of assistance, refusing services because of a lack of scientific data becomes unethical for professionals working directly with students.

Separately, Wilder Research found several policies and interventions—such as school uniform policies, and financial sanctions levied against parents of truants—were not aiding the improvement of attendance for students demonstrating school refusal or chronic truancy.

Purpose of Graduate Project

The purpose of this project is to create a protocol for identifying students who may be at-risk for developing school refusal behaviors and identifying students who are already engaged in refusal behavior. School psychologists, psychiatric social workers, and pupil services and attendance counselors within three Los Angeles County school districts have confirmed in informal interviews that no standard treatment protocol is in place at their schools for students who demonstrate school refusal behavior. Until the absences reach critical mass and the school is required to attend to the matter, the only action taken regarding individual student absence are calls by school office staff (often “robo-calls”) in an effort to confirm whether the absences were or were not condoned by parents. Moreover, many schools in one observed district do not even have a disciplinary action plan in place when the absences qualify as truancy.

When student absences meet the high bar set by individual schools for problematic absenteeism, pupil service professionals within the schools are typically ill equipped and untrained to deal effectively with this problematic behavior. Service professionals are not aware of the appropriate and effective research-based interventions available, and they have little understanding of the function of the behavior to begin with.

In response to this lack, this project proposes a treatment map that will provide suggested criteria for defining school refusal behavior qualitatively and quantitatively. Formal and informal assessments aimed at determining causal elements and determinants for school refusal behavior will be suggested. In Addition, the project will assist pupil service professionals with selecting appropriate, evidence-based Tier 2 and Tier 3 interventions for school refusing students according to the student’s functional, or pathological, profile.

Tier 2 interventions will be considered for students who reach the lower threshold for partial or full day absences (10% for the purpose of this project, for a two month period) using a problem-solving approach. This approach will make use of a Student Study Team, or a Coordination of Services Team, which requires, at a minimum, a review of school records, teacher interviews, parent interviews, and student interviews (if possible). At this tier, school record review will focus on looking at predictive demographic factors which put the student at greater risk for continuation of school refusal behaviors, or, more distally, eventual dropout. Students that meet several of the demographic predictors for dropout will be offered appropriate directed interventions. Intervention will be guided by use of formal evaluations that employ normal tools used to identify student pathology (of functional etiology) for the school refusal behavior. Treatment may include any combination of family therapy, group therapy, individual counseling, or behavioral interventions at home and in school.

Tier 3 students will need to meet a higher threshold for partial or full day absences (25% or more for the purpose of this project, for a two month period) and will be evaluated for appropriate treatment in the same manner as Tier 2 students (e.g., record review, interviews, observations, and formal social-emotional assessments). In Addition, Tier 2 students can be stepped-up to Tier 3 if the intensity of Tier 2 interventions did not produce improvement in attendance. At Tier 3, interventions will differ from Tier 2 interventions only in terms of intensity and duration.

Terminology

Basic terminology, when not specifically illustrated in cited research, will refer to the following concepts as defined below. For the purpose of the project, the following definitions will be used because they illustrate student behaviors and school constructs broadly enough to serve as a protective measure for students who, perhaps, need assistance with school refusal behavior before it becomes so entrenched as to be nearly unfixable.

School Refusal / School Refusal Behaviors: Child-motivated refusal to attend school or difficulties remaining in classes for an entire day for children within the 5 – 17 year old age range (Kearney, 2001).

Truancy: School refusal behavior motivated by the desire to pursue desirable activities outside of school during school hours without parental permission (Kearney, 2001).

School Avoidance: The absences that are motivated by school phobia (see below) (Kearney, 2001).

School Phobia: School phobia is school refusal behavior motivated by depression or anxiety. Performance based anxiety or social anxiety are typical underlying anxieties for these students.

Problematic Absenteeism: School refusal behavior that is either parentally condoned or otherwise, and interferes with student access to curriculum and development of social skills (Kearney, 2001).

At-Risk Students: Students who demonstrate predictive demographic factors that increase their chances for dropout (e.g., lower SES, lower parental involvement, students who have been retained in a grade) (Kearney, 2001).

Dropout: Leaving school before high school graduation, either with or without a General

Education Diploma (GED). Students who later graduate from college are (still) included in this category (Kearney, 2001).

Grade Retention: Holding a student back from promoting to the next grade due to lack of academic progress (Kearney, 2001).

Social Promotion: Promoting a student to the next grade regardless of inadequate academic progress in the current (or previous) grade (Kearney, 2001).

Formal Assessment: Norm-referenced assessments used to measure cognitive, social-emotional, affective, and academic status for students and/or adults (Kearney, 2001).

Social-Emotional Assessment: Norm-referenced assessments used to measure social-emotional states or traits (Kearney, 2001).

Interventions: The process of intervening in an academic, social-emotional, affective, or behavioral area with the intent of improving adaptive behavior or affect or supporting developmental growth in these areas (Kearney, 2001).

Universal / Tier 1 Interventions: Interventions designed to support the whole student body at a school or district in any intervention area (Kearney, 2001).

Tier 2 Interventions: Targeted interventions designed to support students who are demonstrating more than expected, or outside of the norm, difficulty with behavior, affect, or academics (Kearney, 2001).

Tier 3 Interventions: Targeted interventions designed to support students who are demonstrating significantly more than expected, or outside of the norm, difficulty with behavior, affect, or academics (Kearney, 2001).

School Records: These records include the cumulative file, electronic record, and other available school-based records used for accumulating historical student data.

School Policy / Systems: A plan or system within schools or whole districts designed to organize activities and determine decisions according to pre-set rules and directives. Most preset rules and directives are designed to support student achievement (Kearney, 2001).

Individualized Education Program (IEP): An IEP is a legal document created by several specialists within the school that offers special services and / or accommodations to students with educationally defined disabilities, develops and tracks student goals, and offers assistance to teachers in making instruction meaningful to these students (Keraney, 2001).

Student Study Team (SST): A team of specialists within the school, usually including the school psychologist, targeted student's teacher, special education teacher, administrator, counselor, and English language acquisition specialist (if the student is a limited English language speaker) who meet at a specified time and place in order to discuss the academic, social, and emotional development of targeted students who have come up as students of concern for teachers. The SST team gathers data and employs a problem-solving model for devising solutions to presenting problems. In Addition, the team assigns responsibility to individual team members to follow-up on the presenting problems and report back to the SST team at a later date (Kearney, 2001).

Designated Instructional Services (DIS): An additional, non-instructional, service provided to student's with existing IEPs, as necessary, which allows the student to educationally benefit from their IEP. These services include language and speech services, adaptive physical education, physical therapy, occupational therapy, and counseling services, and others not listed herein (Kearney, 2001).

Summary

This project identifies several predictive factors for students which may lead or contribute to school refusal and, potentially, eventual dropout. An ecological systems perspective is considered with potential causal factors explored including society at large, school systems, teachers and school staff, parents and parenting, academics, and student factors.

Existing systemic and therapeutic interventions are considered at each ecological level, with an emphasis on *student* factors, parents, and parenting. In Addition, school systems considerations relative to staff and expertise are explored in order to connect students with providers, and suggest useful, effective interventions according to student's specific and demonstrated needs in the area of school refusal.

Chapter 2 – Literature Review

Introduction

This literature review consists of several sub-sections, each broken down following a review of Bronfenbrenner's (1979) Ecological Systems Theory. These sub-sections fall under the headings: *student characteristics*, *family characteristics*, and *school factors*. Each are explored relative to their direct, indirect, or interdependent contribution to school refusal behaviors, and are approached as mutually constitutive and interacting factors within the educational ecosystem. Before engaging in a detailed review of each of these sub-sections, the reader is provided a more general overview to the academic research on school refusal behavior as an introduction to the more specific literature.

School Refusal: A General Review

Examples of mutually enforcing school refusal behaviors are worth exploring to highlight as introductory points. For instance, low familial SES is highly correlated with single parent households and limited academic support, which is predictive of lower academic achievement, which in turn promotes increases of psychosocial stressors (Goldschmidt & Wang, 1999). Psychosocial stressors are themselves a risk factor in the development of new psychological disorders (Najman, Mohammad, Clavarino, Bor, O'Callaghan, & Williams, 2010), which can compound further school refusal behavior (Wimmer, 2008). This cycle demonstrates how school refusal behavior can increase in likelihood in an exponential way, driven by interrelated and progressive risk factors.

Further, many students who demonstrate school refusal behavior do not receive special education services. At the federal level, in 1977, the United States reauthorized the Individuals with Disabilities in Education Act (IDEA) and assigned states the responsibility to design programs to meet the needs of students who are offered special education services. In Addition, states were required to find children through Child Find that might be in need of special education services. Some students who receive special education services are offered designated instructional services (DIS) as part of their Individualized Educational Program (IEP). In cases where emotionality or inadequate social competence interferes with the student's access to instruction within the classroom, the DIS services might include counseling to address issues such as anxiety, depression, disruptive disorders, or lack of social skills. Unfortunately, most school refusing students are not offered these social-emotional supports. Ideally, schools should consider offering tiered intervention services without a present or active IEP for students who demonstrate these behaviors. In

some cases, conducting a psycho-educational evaluation may be a better protocol.

However, with only parental consent and student assent, interventions can be offered in a timelier manner, before behaviors become more functionally reinforcing or more pathologically entrenched for the student.

It is difficult to tease apart the various factors that contribute to school refusal behavior because most of the factors cannot be conceived apart from one another, and are often mutually reinforcing. To help conceptualize this complexity, Brofenbrenner's (1979) Ecological Systems Theory is introduced to illustrate the different systems that operate to produce negative affect for students who demonstrate school refusal and, potentially, eventual dropout.

Interdependent Ecological Systems

Research on school refusal behavior is informed, in part, by Urie Brofenbrenner's (1979) Ecological Systems Theory, which recognizes that individuals act within ever broadening but interdependent systems that affect the development of child behavior and personality. These ecological systems inform the risk and resiliency factors within one's life. The relationship between the individual and the various systems is bidirectional; systems not only act upon individuals, but individuals can change the context of the systems.

Brofenbrenner (1979) identified five environmental systems within which an individual interacts. The most proximal to an individual is the *microsystem*, which includes the individual him/herself, the individual's family, school, peers, church affiliation, workplace, and neighborhood.

The next concentricity is the *mesosystem*, which includes interactions between all players in the microsystem. For example, if there are significant risk factors such as poverty and negative influences such as domestic violence within the microsystem or mesosystem, a growing child might develop schemas which generate negative expectations of others and minimized or highly negative expressions of self. Negative themes and risk factors can be measured and studied using several projective psychological assessment tools including Roberts Apperception Test, Draw a Person, and the Person-House-Tree Drawing test. Other strategies include formal social-emotional assessment tools such as the Behavioral Assessment System for Children, the Revised Manifest Anxiety Scale, and the Child Depression Inventory. These tools and more can be used to measure the issues emerging in the micro- and mesosystems of an individual's psychological life.

The next layer in Brofenbrenner's schema is the *exosystem*, which includes the

greater economic, political, educational, governmental, and moral or religious systems of which an individual is a part. Governmental, school, or local community systems may be in place (or be absent) to help mitigate or aggravate the problems present at the level of the mesosystem or microsystem. For example, there might be community resources which offer free or reduced cost childcare for the working-poor or free English language development classes for non-English speaking adults which will contribute to resiliency factors within the more direct and proximal systems. In addition, school systems at the district or state level, might offer student supports which target academic achievement, improved mental health, and pro-social training, all of which support academic achievement, improved attendance, and high school graduation rates.

The next layer is the *macrosystem*, which includes all overarching beliefs and values that an individual holds. This level includes an individual's internalized expectations that have been informed by parental expectations and cultural influences, including stereotypes, from the broader culture. These internalized expectations guide behavior and add context to the development of personal identity. A child can experience significant cognitive and cultural dissonance if s/he does not fit into the broader culture, and the family's cultural heritage does not provide adequate resiliency to support either acculturation to the dominant culture or individuation from the dominant culture.

The final layer is the *chronosystem*, which holds the timeline that informs the other layers by providing an overarching historical framework (Salkind, 2012). This dimension of the ecological system contains the cultural zeitgeist of the time and informs the larger culture's values and prejudices. Groupthink can support or impede personal progress and set limited expectations for individuals based on race, socio-economic status, or achievement.

The micro-, meso-, exo-, macro-, and chronosystems round out Brofenbrenner's ecological thinking about individuals and systems.

In line with Brofenbrenner's Ecological Systems Theory, predictors and determinants of school refusal tend to have a hierarchical structure, with some predictors built upon previous determinants. We can find several examples of the mutually constitutive nature of school refusal behavior in the extant literature, reviewed below.

Overview of the Research: An Ecological Systems Approach

A prime example of the mutually constituting nature of refusal behavior comes from a study which shows that poor parent-child bonding hinders positive peer relationships, which hinders academic performance in class, which contributes to decreased attendance, which is positively correlated with school refusal behaviors and high school dropout rates, and so on. This researcher examined these interrelated constructs and hypothesized that dropping out is a result of current circumstances (e.g., current risks and resiliencies) and prior development (e.g., previous experiences which contributed to current risks and resiliencies) (Jimerson, Egeland, Sroufe, & Carlson, 2000). The sample for this study was taken from a group of mothers who were pregnant or had young children who received prenatal or early child-care from the Maternal and Infant Care Clinic of the Minneapolis Health Department. Measures considered in analysis were Family Factors and Child Factors. Family factors included early quality of caregiving, overall maternal sensitivity, quality of infant-mother attachment relationship, quality of problem-solving support, quality of early home environment, SES, and parent involvement at school (Jimerson et al, 2000). Child factors included assessment scores on the Wechsler Intelligence Scale for Children-Revised, Peabody Individual Achievement Test, Woodcock-Johnson Achievement Test-Revised, problem behaviors, and peer competence (Jimerson et al, 2000).

Jimerson et al's (2000) analysis showed that Problem Behaviors (in sixth grade) emerged as one of the best overall predictors in determining which students would drop out of high school, followed by Quality of Caregiving (at twelve and twenty-four months), Parent Involvement (in sixth grade), Problem Behaviors (in first grade), Gender, SES (in third Grade), Home Environment (at thirty months), Peer Competence (in first Grade), Peer

Competence (in sixth Grade), WISC scores (in third grade), Academic Achievement (in first grade), and finally Academic Achievement (in sixth grade). This study suggests that professionals such as school psychologists, teachers, and school administrators, in addition to parents, should attempt to foster an environment that would support these determinants at the specific developmental stage where their importance becomes most predictive of later school success since well-timed supports will likely decrease school dropout rates (Jimerson et al, 2000).

An unmeasured correlate of this study is the relationship between quality of caregiving and child and adolescent depression and anxiety, which is another contributing factor in school refusal behavior and high school dropout rates (Burt, 2002; Egeland, Sroufe, & Carlson, 2000). Specifically, “early experiences may affect the self-esteem and sense of agency that may directly influence school performance and decisions to staying school, and may also lay foundations for behavioral control and relations with teachers and peers that further propel the individual [student] along a pathway toward dropping out” (Jimerson et al, 2000, p. 543). Another major limitation of the study is that the sample group, as a whole, was at risk for poverty (which is an existing determinant for increased school absenteeism, school refusal behavior, and high school dropout rates), and that the sample was collected from a small geographical area, which suggests increased homogeneity in social supports and risk factors.

The Search Institute (2011) also provides helpful research in understanding the nature of school refusal behavior from an ecological systems perspective. Students, especially those who experience personal, familial, and community risk factors need additional support to increase academic achievement, discourage problematic absenteeism, and increase

graduation rates. The Search Institute developed a list of forty Developmental Assets for children, targeted to children's separate developmental levels (e.g., young childhood, middle childhood, and adolescence), that plainly illustrates resiliency factors that contribute to promoting a positive attitude, increasing positive actions, and reducing risky behaviors in childhood (2011).

The assets are divided into two broad categories, External and Internal, which are further broken down into smaller conceptual categories, with each category supported by several positive mental attitudes or behavioral strengths. For adolescents in the area of External Assets, conceptual categories include External Support (from Family, School, Community, Non-Family Adults), Empowerment (Community Values Youth, Youth as Community Resource, Service to Others, Safety), Boundaries and Expectations (Family, School, Neighborhood, Adults Role Models, Positive Peer Influence, High Expectations), and Constructive Use of Time (Creative Activities, Youth Programs, Religious Community, Time at Home). In the area of Internal Assets, conceptual categories include a Commitment to Learning (Achievement Motivation, School Engagement, Homework, Bonding to School, Reading for Pleasure), Positive Values (Caring, Equality and Social Justice, Integrity, Honesty, Responsibility, Restraint), Social Competencies (Planning and Decision Making, Interpersonal Competence, Resistance Skills, Peaceful Conflict Resolution), and Positive Identity (Personal power, Self-Esteem, Sense of Purpose, Positive View of Personal Future) (The Search Institute, 2011).

The Search Institute offers simple action-oriented suggestions for increasing assets at each level of the ecological system (the individual level, the family level, the school level, the community level, and partnerships between them). For example, at the family level, to

offer External Support, parents can spend time with each child individually and take time to acknowledge external achievements and identify positive internal attitudes (The Search Institute, 2011).

The National Dropout Prevention Center emphasizes the identification and development of external assets in order to support high school graduation. For example, Accelerated Learning Center generated a “high effectiveness” rating that includes high expectations around academic achievement, community collaboration, and family and parental involvement at school. These intervention areas are embedded into several developmental assets. The assets provide a basic outline for protecting students against engaging in high-risk behaviors, and if the student is already engaging in risky behaviors, the interventions help to mitigate the resultant damage.

Four areas of high-risk behavior have been identified as the most significant deleterious influences on a child’s quality of life and ability to thrive: problematic alcohol abuse, violence, illicit drug use, and sexual activity. Add to this a secondary tier that includes tobacco use, depression, suicidality, antisocial behavior, school problems, driving under the influence of drugs or alcohol, and gambling (The Search Institute, 2011). Significantly, these behaviors can be found in the qualitative criterion for various mental disorders listed in the Diagnostic and Statistical Manual for Mental Disorders, 4th Edition, Text Revision (DSM).

In a 2003 study by The Search Institute, researchers found that African American, American Indian, Asian American, Latino/a, White and multicultural youth all enjoy similar benefits and a mitigation of risk factors after exposure to some of the forty Developmental Assets. The aggregate dataset included 217, 277 students of various racial and ethnic

groups from grade six to twelve who were surveyed with regard to the presence of developmental assets within their lives from 1999-2000. Developmental Assets benefited all students across grades, race, ethnicity, and SES relatively equally, serving as a protective measure against engaging in ten separate high-risk behaviors including alcohol abuse, violence, drug use, and sexual activity, amongst other activities. In Addition, the study suggested that specific assets show greater correlation with reducing at-risk behaviors or offering a protective measure in spite of the presence of said behaviors. For example, constructive-use-of-time is more strongly correlated with Indian and Asian American youth as opposed to White, Non-Hispanic youth (The Search Institute, 2011).

Student Characteristics

Specific student characteristics contribute greatly to student success (or lack thereof) at school. Providing an overview of the psychosocial research on the student characteristics that contribute to school refusal behavior helps to provide support to researchers looking to map and create new solutions to mitigate refusal incidents. The research reviewed below focuses explicitly on studies that emphasize the student characteristics that lead to success or failure during school years.

Student characteristics highly predictive of school refusal and high school dropout were race, grade retention, misbehavior (defined by delinquency outside of school and school suspensions), working more than twenty hours per week, remedial English, and low reading and/or math scores on standardized tests (Goldschmidt & Wang, 1999). The study showed that race becomes less predictive when it is held constant and SES better accounts for the racial differences in high school dropout.

Certain psychosocial weaknesses or disorders also contribute to school refusal; however, other determinants such as academic achievement, attitudes, and behaviors also play a role in student absences (Hagborg & Masella, 1991). Academic achievement refers to student's test scores in all grades, but success in certain grades can be more predictive of school refusal or dropout than others. For example, low academic achievement in Kindergarten through third grade, seventh grade, and eleventh grade are strongly correlated with later school refusal and dropout rates. Grade retention is the single biggest factor in predicting later truancy and dropout potential (Hagborg & Masella, 1991).

A specific characteristic that has been shown to predict school refusal or dropout is student engagement, or lack thereof. This includes engagement with academic work within

the classrooms and at home, plus engagement in social aspects of school such as clubs. In Addition, high absenteeism is a behavioral indicator of school refusal and a predictive variable in school dropout. Behaviors such as early sexual activity, drug and alcohol use, and engaging in criminal or delinquent behavior also decrease the likelihood that a student will graduate on time, if at all. These behaviors are also positively correlated with psychological problems or social-emotional difficulties. Finally, students who work twenty or more hours per week are at greater risk to demonstrate school refusal behavior or dropout. Student attitudes toward school also predict future attendance behavior. For example, students who self-report expectations that they will succeed have a higher graduation rate than those set the bar lower for themselves (Rumberger & Lim, 2008).

Further studies have been conducted with the aim of finding predictive factors or determinants that increase the likelihood of school refusal or high school dropout. In the longitudinal Children in Community Study (CICS) a cohort of 967 children from randomly sampled households from two counties in upstate New York were followed from 1975 through 1983 (Stoep et al, 2003). In 1975 all the children in the study were between one and ten years old, evenly distributed by gender. Families from this sample were given structured diagnostic interviews in 1983 that yielded psychiatric disorders in four categories: anxiety, depression, substance abuse, and disruptive disorders.

During the initial interview, roughly 18.2% of the children met the criteria for psychological disorders. A follow-up interview was conducted two and a half years later, and found a significant difference between the high school completion rates for children with psychological disorders versus those without psychological disorders at the time of the initial interview. Within the smaller sample of children, specifically the 18.2% with psychological

disorders, roughly 39% did not complete high school, whereas only 7% of the adolescents without psychological disorders did not complete high school (Stoep et al. 2003).

When socio-economic status (SES) is controlled, Stoep et al. (2003) found that psychological disorders are responsible for 44% of school failure for lower SES families and 61% of school failure in upper SES families. Limitations to the study center again on a homogenous sample population: two New York counties that were predominately white. This is a problem for the study because, historically, non-white students drop out at higher rates than white students, which might account in part for the lower total percentages of students who failed to complete high school in the CICS (13%) versus the total in the broader United States population (19%) at the time of the study. In Addition, the study did not explore the correlations between the specific psychological disorders diagnosed (or the age of onset) with the failure to complete high school. The psychological reference material in itself is limited in this regard.

The Diagnostic and Statistical Manual for Mental Disorders, 4th Edition, Text Revision (DSM), for example, does not include a diagnostic category for School Refusal but it is indicated as a symptom of many adolescent and childhood mental disorders. Separation Anxiety Disorder, Phobia, Depression, Anxiety, Oppositional Defiant Disorder, Overanxious Disorder, Avoidant Disorder, Social Phobia, Agoraphobia, and Conduct Disorder all include diagnostic criteria that accommodate school refusal behavior (Kearney & Silverman, 1996).

It is the presence of school refusal, as a diagnostic criterion across many existing mental disorders, which indicates that treatment modalities may already exist, in part or in whole, and might assist in treating refusal behavior. Still, the Kearney and Silverman

(1996) note that simplifying school refusal behavior into an *internalizing* school refusal versus an *externalizing* school truancy duality does not account for the full spectrum of causal factors or determinants that may be at play in supporting the behavior. In Addition, the behavior subsumed within various DSM diagnoses does not account for the individual differences between clinical and non-clinical populations who demonstrate school refusal behavior. Instead of relying upon the DSM, these functional determinants of school refusal can be identified using various assessment instruments such as the Achenbach System of Empirically Based Assessment (ASEBA), Child Behavior Checklist or Teacher Report Form (Kearney & Silverman, 1996).

In addition to the ASEBA, other instruments may assist supporting clinically significant findings such as the Child Depression Inventory, the Behavioral Assessment System for Children, and the Revised Manifest Anxiety Scale for Children. Record review, observations of patterns in absences (excused or otherwise), and interviews with teachers and parents should support use of standardized assessment tools and assist with supporting results derived from such tools. Limitations mentioned by the authors include inadequate classification tools for identifying different school refusal types and lack of interface between assessment and treatment (Kearney & Silverman, 1996).

Additional assessments are available to assess the potential determinants or support for school refusal behavior. One instrument which is specifically designed for such use is The School Refusal Assessment Scale, Revised, (SRAS-R); it is a norm referenced test which is sensitive to anxiety, depression, avoidance behaviors, and preference for more desirable activities. The SRAS-R has a Likert scale and includes parent and child forms. In addition to forms, a records review is an important pre-intervention duty.

Switching gears to a 2001 Australian and New Zealand study of adolescents demonstrating school refusal behavior, researchers investigated characteristics of 192 adolescents who had been treated at a Sydney hospital in both inpatient and outpatient settings (McShane, Waler, & Rey, 2001). The researchers examined extant records for students treated between 1994 and 1998 in the hospital and developed an instrument to use for gathering data from the files. Researchers noted that the students from the study typically started to demonstrate school refusal during the first two years of high school (McShane et al, 2001). Studies from the United States typically demonstrate a significant increase in school refusal behavior or problematic absenteeism in high school, but there is a statistical spike in this problematic behavior beginning in middle school too; the middle school spike was largely absent in Australia and New Zealand (Christendson & Thurlow, 2004). A family history of psychopathology was present in more than half of the students, and students presented with comorbid conditions such as anxiety, mood disorders, and disruptive disorders in addition to school refusal. The McShane et al (2001) study hypothesized that students demonstrating school refusal behavior would have underlying anxiety and/or depression, and that students admitted to inpatient treatment would have more significant psychological impairments. Family dynamics, external stressors, and academic difficulties would be functional predictors as they activate underlying anxiety or depression, effectively causing student-directed problematic absenteeism (McShane et al, 2001).

Treatments offered at the hospital included graded exposure, individual cognitive behavior therapy, family therapy, and psychotropic medications, if needed. Students referred to the hospital clinic had significant absences from school with concomitant parent report (via the Aseba Child Behavior Checklist) that the child “fears school”. The

instrument developed to gather data examined patient gender, hospital status (inpatient, outpatient, assessment only), age of onset of school refusal, relevant proximal events (e.g., moving to a new school, parent divorce), number of schools attended, student use of psychotropic medications, family psychiatric history / parent psychopathology, family composition, Global Assessment of Functioning (GAF) at initial assessment, a social-emotional-behavioral assessment (Aseba Child Behavior Checklist), a formal depression assessment, parent level of education, and length of admission for inpatient students (McShane et al, 2001). In the sample of 192 students, 55% were male, mean age at assessment was 14.2 years, approximately half of the students were admitted to inpatient treatment after the initial assessment for an average of 13 weeks, one-third were offered outpatient treatment, and the remainder were assessed and referred elsewhere or did not meet the criterion set for treatment. In 80% of the cases, school refusal behavior had been present for two years, and the researchers found that 12.3 years was the mean age for the onset of school refusal behavior (McShane et al, 2001).

This age of onset matches the United States modal spike in school refusal behavior beginning in middle school (Christendson & Thurlow, 2004; Rumberger, 1995). Intake interviews indicated that most students had experienced a proximal setting event near the time when their school refusal began (e.g., family conflict, parent divorce, parental sickness, students sickness, or moving house), and most students had been to four schools at the time of their initial intake. More than half of the sample came from an intact two-parent family and one-third came from a single parent household. In Addition, academic difficulties were present in one-third of the sample, however they were not quantified (McShane et al, 2001). Global Assessment of Functioning scores , as defined by the DSM, at intake were

significantly compromised with a mean score of fifty-four (on a scale where one identifies extreme functional impairment and 100 identifies superior functioning across most domains) and depression standard scores indicated significant depression, with no significant difference between inpatient versus outpatient treatment groups. Anxiety, mood disorders, and disruptive behavior disorder were represented more frequently in the outpatient students. Comorbidity was significant for all students in the sample, with Dysthymia and Major Depressive Disorder occurring more frequently with inpatients and Separation Anxiety Disorder, Panic Disorder, and Oppositional Defiant Disorder occurring more frequently with outpatients (McShane et al, 2001).

Two major limitations to this study were lack of control group, and the non-randomized sample of students. The McShane et al (2001) study is consistent with other research indicating that school refusal behavior serves a function, and that the function is often modulated by personal pathology (Kearney & Silverman, 1996, p.343).

Another study of school refusing adolescents involved evaluating differences in coping mechanisms between school refusing and non-refusing students (Place et al 2002). The twenty-two families chosen to participate in the study met the minimum criteria for age (twelve to sixteen years old) and the minimum criteria for absences that were set at four consecutive weeks. Formal social-emotional assessments including the Adolescent Coping Scale (ACS) were administered to students to assess their internal and external supports, and formal assessments including the General Health Questionnaire (GHQ) were administered to parents to assess their mental health. Both parents and children were administered the Family Adaptability and Cohesion Evaluation Scales (FACES II) to assess each family member's perception of familial adaptability and cohesion. Additional demographic data

such as family structure, academic achievement, SES, and gender were also assessed (Place et al, 2002). The researchers suggested that increased social isolation and poor socialization occurs more often within enmeshed families, and this poor modeling at home generalizes to poor interpersonal relationships within the school and poor coping strategies (Place et al, 2002).

Children from enmeshed families have not developed the social skills necessary for transferring power and influence from parental figures to peers. In Addition, the transition to middle school and high school typically introduce students to a larger and more complex social environment, requiring adolescents to be more flexible and adaptive in their response to social cues. As such, it is no surprise that modal spikes in school refusal behavior occur in middle school and beginning high school (Christendson & Thurlow, 2004). Results from the FACES questionnaire for all the families demonstrated high levels of enmeshment for the study students, with the majority of the families showing enmeshed but flexible family dynamics, and one third showing chaotic, enmeshed family dynamics, and final percentage belonging to a single family that demonstrated a rigidly enmeshed family dynamic (Place et al, 2002).

The study found that coping mechanisms demonstrated by school refusers was significantly less effective at identifying systematic methods for solving problems, that school refusers did not perceive effort would solve or mitigate problems, and that these students did not have adequate internal or external supports to indicate that problems can often be solved (Place et al, 2002). In Addition, enmeshed families tend to demonstrate significantly more anxiety than more adaptive families, which further complicates student characteristics and creates another functional reinforcement for school refusal (Kearney &

Silverman, 1995).

These school-refusing students might benefit from treatment with individual and/or group cognitive behavioral therapy in order to reduce automaticity of negative expectations and accompanying inaction (King, Tonge, Heyne & Ollendick, 2000; Kearney, 2003). In Addition, family therapy, including restructuring parental commands and contingency training, would benefit these students, and their families by proxy, by illustrating dysfunctional family structures and patterns of interaction that support ineffective problem solving strategies for students at school and family members at home (Place et al, 2002; Kearney, 2003).

Family Characteristics

A 1999 study by Goldschmidt and Wang determined that family characteristics play an important role in predicting school refusal behavior in students. Specifically, family characteristics that are positively correlated with increased student dropout are single parent families, lower SES, and families where parents have not obtained a high school education (Goldschmidt & Wang, 1999). Sadly, these same family factors are correlated with non-white races and lower academic achievement.

Families with lower SES also tend to have less quality time to spend with children, instead spending more time at work, which contributes to decreased parent-child socialization and increases the likelihood that a parent will engage in authoritarian, permissive, or neglectful parenting (Goldschmidt & Wang, 1999). The National Association of School Psychologist's (NASP) position statement regarding effective parenting directs parents to develop a trusting relationship with their children, develop age appropriate (high) expectations, set limits and enforce them, and offer encouragement and recognition (NASP, n.d.). When parents do not provide support in these areas, children have a diminished sense of what they can do and have less support moving in positive directions.

Parents are active agents in shaping their children's futures. For example, parents who expect their first grade children to do well in school visit the library more often than do parents with lower expectations; their belief and expectation guides their current parenting practices (Alexander, Entwisle, & Kabbani, 2001). The belief in children's ability and expectation of positive outcomes, especially when sustained over the child's academic career, supports and guides children along the path to school completion. Presumably, most

parents implicitly understand that their involvement and interest in their child's academic life will benefit their child; however, they may not realize that their lack of involvement or interest will likely hinder their child's academic success.

Unlike at home, where parents typically have a more direct and authoritative role, parents' role at school is peripheral at best. As such, parents do not necessarily understand that their present-day parenting behavior in the area of school is a determinant in their child's future success. According to a 2001 study, parental engagement, as measured in first grade, separates future dropouts from future graduates almost as effectively as behaviors nine years later (Alexander et al). As for the students themselves, self-doubts and low psychological engagement with school at age six or first grade are positively correlated with increased school refusal and a greater likelihood of high school dropout (Alexander et al, 2001).

Parental attitudes were also measured during the student's ninth year of school. On various occasions over the years, parents were queried about their children's ability to do schoolwork, how far they expected their children to go through school, and their mark expectations for upcoming report cards. Standardized "parental attitude" scales were constructed from these items year-by-year. The first grade and year nine measures are used individually; the others are averaged across years to derive measures for years two to five and years six to eight (Alexander et al, 2001). Parental attitude scores in the "favorable" range engaged in high expectations when compared to the norm, whereas parental attitude scores in the "unfavorable" range engaged in low expectations when compared to the norm. When "favorable" parental attitudes were compared with "unfavorable" parental attitudes, results indicated a significant difference in student outcomes over time. Results indicated that, when parental attitudes were assessed, roughly 56% of children drop out when parental

support is “unfavorable” versus 27% when parental support “favorable”. An extra measure of controlling for the representative heuristic was taken before the first parental attitude in first grade. Parent interviews were completed before issuance of first quarter marks and so control for parental expectations of children’s grades moving forward (Alexander et al, 2001).

Kearney and Silverman studied maladaptive parent-child relationships as a construct that supports child and adolescent psychological disorders, which are positively correlated with school refusal behavior, truancy, and high school dropout (1995). Parental psychopathology has an effect on parent-child relationships too, further complicating the parent-child bond and serves to either increase or decrease parental support of children (Christendson & Thurlow, 2004; Kearney & Silverman, 1995).

Kearny and Silverman (1995) also studied types of family relationships, which were identified for school refusing students using the Family Environment Scale, with the understanding that many families included mixed familial types. The five identified family types were: 1) enmeshed parent-child dyads, characterized by dependency and overindulgence; 2) conflictive families, characterized by high rates of coercion, noncompliance, and aggression; 3) detached families, characterized by diffusion of activity and little interfamilial interaction; 4) isolated families, characterized by little extrafamilial contact; and 5) healthy families with a child with an individualized psychopathology (Kearney & Silverman, 1995). Different treatment modalities can be used depending upon the family type, which may mitigate student school refusal. For example, family therapy can assist in reducing enmeshment between the parent-child dyad. Kearney and Silverman analyzed previous studies and generated five dysfunctional family subtypes in order to

deliver targeted therapy as a primary or adjunct support for reducing school refusal (1995).

In a longitudinal study, researchers examined family factors, especially parenting, and quality of caregiving prior to elementary school attendance in order to determine possible prerequisites and developmental trajectories for students who might eventually drop out of school (Jimerson et al, 2000,). In line with developmental theory, researchers hypothesized that intrinsic trait factors, coupled with early childhood developmental factors, would effectively set up a child's behavior and expectations of the world.

One significant limitation of the Jimerson et al (2000) study is that students who did not graduate from a traditional high school and students who were enrolled in an alternative educational setting were dropped from the study. This is important to note because The Center for Dropout Prevention (2011) recognizes the importance of alternative education, service-learning models, and other non-traditional schooling models. A second significant limitation is that the study focused on mother-child relationship during pre-schooling years, which is typical, but not necessarily the strongest determinant for development. For example, the father can be the primary caregiver and, therefore, a stronger determinant for the child's developmental trajectory.

Further, the Early Quality of Caregiving Composite, used in Jimerson et al's (2000) study, measured overall maternal sensitivity, quality of infant and mother attachment during playtime, feeding time at both twelve and eighteen months, the structure and limit-setting demonstrated by the mother on a series of tasks, and the quality of parental instruction surrounding limit setting at forty-two months of age. Maternal sensitivity was rated using Ainsworth, Blehar, Waters, and Wall's scale, which includes maternal awareness of infant signals, accurate interpretation of said signals, and appropriate and prompt response to said

signals. Mother-child attachment was measured using Ainsworth's strange situation rating system which scores infant response to the stress of separation, infant response to reunion with parent, and response to strangers both with and without maternal presence. The three attachment style ratings are secure, insecure-avoidant, or insecure-resistant. Further testing was conducted on maternal structure and limit setting was tested through a series of teaching task situations wherein mother and child were required to solve tasks such as building specific block towers, a naming activity, matching activities, and tracing activities (Jimerson et al, 2000). To measure home environment, trained observers used the Home Observations for Measurement of Environment (HOME) assessment tool, which uses a semi-structured interview format, observations, and a Likert survey in determining the quality of the home environment (Jimerson et al, 2000).

The six subscales included in the HOME survey were Emotional and Verbal Responsivity of Parents, Acceptance of Child's Behavior, Organization of Physical and Temporal Environment, Provision of Appropriate Play material, Parental Involvement with Child, and Opportunities for Variety in Daily Stimulation (Jimerson et al, 2000). As predicted, regression models demonstrated a significant relationship between the early quality of caregiving and the early home environment with later academic achievement, problem behaviors, peer relations, and parent involvement at sixth grade, all of which were measured independently during elementary school and adolescence with the study participants (Jimerson et al, 2000). These variables are highly correlated with school dropout and school refusal.

Rotto and Kratochwill (1994) conducted a study where parents of non-compliant school-aged children were offered a behavioral consultation intervention, which was

designed to increase parental effectiveness. Treatment involved teaching and training parents in contingency management (e.g., rewarding desirable targeted behavior, and punishing undesirable targeted behavior), and training parents how to give commands or directives to their children. In line with NASP's position statement, Kearney (2001) reports that parent-child relationships, especially parent-child communication, is a big contributor to school refusal behavior, and reports that parental effectiveness training may assist in improving school attendance outcomes.

Exploring other areas, Rotto and Kratochwill (1994) focused much of their research on contingency management training, where parents were trained in differential attending (i.e., ignoring undesirable behaviors instead of attending to them unless the behavior was a targeted undesirable behavior, and use of time-outs) and in the area of parental instruction. Participants were trained in communicating child directives clearly, including a time-frame for directive / command completion. The study used didactic communication, written instruction, role-play, and video training for both of the treatment areas (Rotto & Kratochwill, 1994).

The ten to twelve week intervention was provided in an outpatient clinic and lasted approximately one to two hours weekly with childcare provided on site at no charge, while data was collected using direct observations at subjects homes (Rotto & Kratochwill, 1994). Kearney (2001) recommends several of these parent training practices for students who are refusing school related to externalizing behaviors, particularly those who are motivated by attention-seeking and those who refuse school to seek tangible rewards outside of school. Rotto and Kratochwill (1994) also found that parents improved targeted skills by the mid-point and end of the intervention period; however, unfortunately, data was partially

collected and not reported for increased or decreased levels of child compliance.

In summation, families with lower SES also tend to have less quality time with children, instead spending more time at work, which contributes to decreased parent-child socialization and increase the likelihood that a parent will engage in authoritarian, permissive or neglectful parenting. NASP's (n.d.) position statement regarding effective parenting directs parents to develop a trusting relationship with their children, develop age appropriate (high) expectations, set limits and enforce them, and offer encouragement and recognition. When parents do not provide support in these areas, children have a diminished sense of what they can do and have less support moving in positive directions.

School Factors

School factors represent an important dimension in and of themselves in school refusal behavior. For example, Martin (2001) examined data from 3,261 British high school students relative to grade retention and social promotion. Within this broader sample, he matched 168 retained students to 168 socially promoted students across demographic variables including age, gender, ability, and SES to control for spurious correlation (Martin, 2011). Martin found that students who were retained had a significantly lower academic self-concept, completed less homework, demonstrated more behavioral problems in school, and were absent with greater frequency than the socially promoted students. In Addition, the retained students had a significantly higher rate of dropping out than students who were socially promoted regardless of ability and grades (Martin, 2011). Retention does not appear to support the desired outcome of increased academic success for non-achieving students.

Another example comes from the Abolish Chronic Truancy (ACT) program implemented by the Office of Juvenile Justice and Delinquency Prevention. Four hundred Los Angeles County schools employ this stepped legal intervention, which illustrates parental responsibility for student attendance, and requires improved attendance lest more intensive legal steps be taken against the parent (2008). Pre-intervention for Tier 2 might also include behavioral reinforcement for school attendance and or timely arrival to classes for middle and high school. There is very little research in place for practitioners that address or inform a more proactive, tiered, targeted model for reducing school refusal in students. The absence of this kind of model can, perhaps, be attributed to a perceived lack of money for such a targeted intervention, and, additionally, the only recently arrived at

paradigm-shift in thinking of school dropout as a process rather than an event.

Crucially, two systemic issues that are directly correlated with dropping out of school are grade retention and lack of systems in place that catch school refusal in a timely manner. A British study looked at systemic renewal as one path to conquer school refusal and truancy problems. In this study, Ken Reid (2004) looked at long-term strategic approaches to tackling truancy and decreasing absenteeism in schools using a Secondary School Three Group intervention (SSTG). The study explored approaches to improving attendance and decreasing school refusal across several urban and rural districts around London. Reid's study looked at a tiered model for school refusal and truancy prevention, with each tier containing a panel-approach to decision making, and each tier focused on different levels of school refusal.

For each targeted student, a student study team convened to discuss the student's absences, review records, and utilize a problem-solving model to determine an appropriate intervention (Reid, 2004). The tier, and members of the panel, was determined in light of the percentage of absences the students demonstrated. For example, if a student was absent for 10-15% of school days, the Tier 1 panel members would be comprised of personnel at the student's school only, and those that are in direct contact with the student such as the teacher, principal, school psychologist, school social worker and, potentially, special education personnel. Panel members would be charged with determining appropriate interventions to improve attendance.

Should Tier 1 interventions fail to improve attendance, or should attendance reach the quantitative level (15 – 25% absences) which necessitated convening a Tier 2 meeting, panel members would be comprised of Tier 1 panel members plus intervention, special education,

and intervention specialists at the district or Local Education Agency (LEA) level. Again, at Tier 2, the panel would use a problem-solving model to identify issues that likely contribute to the continued and excessive absences; students with the highest levels of absenteeism (35% or higher) or those where Tier 2 interventions failed, are eventually referred to Tier 3 for interventions.

At Tier 3, the LEA Governor, which would translate to an attorney at the LEA, County or State level in the United States, becomes an important member of the panel, delineating punitive action steps (Reid, 2004). Typically, Tier 1 interventions do not employ a punitive model for increasing attendance, and Tier 2 interventions inform parents that legal action is possible if attendance problems are not resolved, whereas Tier 3 interventions clearly deliberate upon the next legal steps required if inattendance and school refusal persists (Reid, 2004). In the Knowsley, England LEA, district attendance improved by more than 5% over the first year after they employed the SSTG intervention model of school reform. The author notes that any kind of intervention requires whole school support and coordination, a tiered approach, and continual progress monitoring to be effective (Reid, 2004).

Within schools, strong attendance is highly correlated with achievement, and poor attendance with poor achievement. In schools, teachers are on the front line in accounting for absences and observing student affect and behaviors. Reid (2004) looked at the views of secondary staff within two English LEAs containing students and families with similar demographics, with similar attendance rates at approximately 90%. Headteachers, Teachers, Heads of Year, and Form Tutors were interviewed about issues related to student inattendance (Reid, 2006). Interview questions were related to the role of LEA education

welfare service, categorizing absences (excused versus unexcused), parental condoned absences, whole day and specific lesson truancy, truancy prosecutions, vocational opportunities within the curriculum, social inclusion policies, school attendance policies, professional development in the area of in/attendance, the perceived causes of inattendance, the value of universal attendance targets, the prioritization of attendance issues, and student holidays during instructional terms (Reid, 2006).

Consensus amongst the interviewees highlighted many problems, including: attendance management as a complex and time consuming task which is typically underfunded; daily practice is not systemized within schools or districts; lack of uniformity in protocol for excused and unexcused absences; difficulty managing student holidays during instructional term; social problems within the school as well as the community; staff's perception of an increase in family dysfunctionality; rigidity of national curriculum; need for alternative curriculum schemes including vocational-training; rise in parental condoned absences; rise in whole day or lesson specific truancy; increased concerns about student safety (e.g. bullying); lack of external financial, personnel, or professional development support in the area of attendance from at the district, LEA, or state level; lack of pre-intervention model for persistent inattendance; and lack of adequate aversive punishment for school inattendance (Reid, 2006).

Within the school system, most parties interviewed felt that universal goals for districts were not realistic or fair-handed because each district contains disparate community demographics, with varying degrees of SES, which markedly affects both parental involvement and community support (Reid, 2006; Reid, 2004). Again, low parental involvement and low parental expectations is highly correlated with student truancy or

inattendance, behavioral problems, and low academic achievement (Reid, 2006; Goldschmidt & Wang, 1999). Headteachers, who were largely held responsible for school-based clerical responsibilities surrounding student attendance in addition to fostering district-wide attendance goals, typically reported feeling overwhelmed by these responsibilities. Deciphering between excused and unexcused absences was perceived to be very difficult, and Headteachers felt pressured to reduce unexcused absences in order to meet district attendance goals and avoid scrutiny, potential legal action, or school-wide auditing (Reid, 2006). Headteachers felt that that presence of a systemic model of parent and student prosecution for truancy would likely be beneficial in increasing attendance, however this systemic model was not in place in either district surveyed, nor was it in place among other districts surveyed in previous studies (Reid, 2006; Reid, 2004).

Broadly, the Reid (2004) (2006) studies indicated that teachers need professional development and schools need systemic renewal with outcome-based protocols for dealing with school refusing or truant youth. The (United States) National Dropout Prevention Center recommends supports across several areas that were indicated in teacher and staff interviews in Reid's 2006 study. These areas include systemic renewal as a continuing process of evaluating goals and objectives related to school policies, practices, and; school-community collaboration which includes the organization of collective community support to students and local schools; and safe learning environments which include school and district level violence prevention programs, conflict resolution programs, and promotion of pro-social behavior (National Dropout Prevention Center, 2011).

Adding another dimension to the problem, The National Center for Dropout Prevention lists grade retention as a significant predictor of school dropout. For example,

Previous studies by Grissom and Shapard (in Hagborg & Gaetano, 1991) noted that grade repeaters were 20-30% more likely to drop out of school before graduating when matched with non-repeaters with similar achievement levels. Hagborg and Gaetano (1991) conducted research regarding how previous grade retention would effect later student academic achievement and personal adjustment. They examined thirty-eight high school students from a rural upstate New York school district with a history of grade retention and matched them with a group of non-retained students. Students receiving special education services were excluded from the study, and the sample consisted of all White subjects with thirty males and eight females. Retained subjects were matched with thirty-eight control students of the same gender who were enrolled in the same classes and attended school on the same track (Hagborg & Gaetano, 1991). Attendance rates, grades, and formal social-emotional assessments were administered to the retained group and the control group.

Hagborg & Gaetano (1991) used Harter's Self-Perception Profile for Children to measure students' self-perception in the areas of academic competence, social acceptance, athletic competence, physical appearance, job competence, romantic appearance, behavioral conduct, close friendships, and global self-worth. Additional formal assessments measuring locus of control were administered to determine whether retained students and control students attributed their success or failure across various domains to internal or external forces (Hagborg & Gaetano, 1991).

School records indicated that retained students earned significantly lower grades than controls, and they were absent from school with greater frequency (Hagborg & Gaetano, 1991). In Addition, social-emotional self-reports indicated that retained students reported lower self-esteem in the areas of social competence, behavioral conduct, and global

self-worth. The researchers found that students retained during later grades had higher attributions for external locus of control than students retained during earlier grades. Social-emotional scores with greater negative affect were positively correlated with poor academic performance both within group and between groups (Hagborg & Gaetano, 1991). The authors noted that the major limitation to the study is the lack of random assignment. Additional limitations include the lack of racial and ethnic diversity within the study sample.

Prevention, Intervention, and Re-Entry

The National Dropout Prevention Center (2011) list several strategies to mitigate school refusal behavior. These Strategies for reducing school refusal are prevention, intervention and re-entry. Prevention programs are focused on mitigating negative predictive factors that contribute to early dropout or bolster resiliency factors which contribute to high school graduation. Areas of focus for prevention programs include increasing family engagement, encouraging systemic renewal that recognizes predictive factors for dropout, school-community collaboration, safe learning environments, early literacy development, and making the most of instruction, amongst others. Areas of focus for re-entry are embedded in the area of systemic renewal; schools should offer service-learning opportunities and alternative schedules and curriculums for students that would otherwise dropout (National Dropout Prevention Center, 2011).

Interventions can cut across several domains including family systems, school systems, academic areas, psychoeducational areas, and social-emotional areas. In Addition, interventions can be tiered in an effort to provide prevention support at the Universal level, or more focused to target specific at-risk students at Tier 2 or Tier 3. The highest tier should be the most precise in targeting students according to the function of their behavior, even when the behavior manifests as school refusal (Kearney & Silverman, 1996). Christendson and Thurlow (2004) would agree with Kearney and Silverman (1996) regarding targeted interventions for at-risk students. Christendson and Thurlow (2004) point out that interventions focusing on students' personal affect, and academic strategies which include high expectations and high support, yield moderate to large effects in improving attendance, and decreasing school refusal behaviors including absenteeism and dropout.

Prevention is often the best intervention, and Baker (2000) looked at early intervention as an important intervention component for school refusing students. The underlying hypothesis for starting a school attendance counseling group is that positive and negative punishment for school absences will increase a student's aversion to school and increase absences (Baker, 2000). Truancy has been associated with increased socially deviant behavior for school children beginning in middle school, making elementary school a good age to begin putting reinforcers in place to decrease student absences.

A supporting example comes from Lynwood elementary school, where forty students were nominated for group inclusion (however, only fourteen consents were returned). The fourteen students were broken into two groups: the primary group consisted of eight first and second graders and the secondary group consisted of six third through fifth grader students (Baker, 2000). The groups met weekly for four months beginning the second semester of school, with the primary group meeting for twenty to twenty-five minutes and the secondary group meeting for thirty-five minutes.

There were three goals for the attendance groups: (1) improve the overall attendance of group members by 50% or more, (2) improve the group members' attitudes toward school and learning, and (3) improve the self-esteem of group members (Baker, 2000). The main goal was to improve attendance and was achieved by the following objectives: creating a supportive group for the students to enjoy, recording each student's daily attendance, assisting students with friendship building and social skills, encouraging positive peer pressure, problem solving to address barriers, and building self-esteem of group members through activities that bring out students' strengths and positive thinking (Baker, 2000).

Group therapy is an important piece of the proposal with the group's dynamics

guiding the treatment. Baker (2000) set weekly attendance goals, and at the end of each session, members received treats (candy, pencils, and stickers) if their attendance was perfect during the preceding week. This increased student buy-in for the program and gave students something to look forward to in school. The weekly groups resulted in increased attendance for thirteen of the fourteen students. All fourteen students exhibited improved attitudes toward school, learning, and increased self-esteem with the primary group data coming from teacher's reports, and the secondary group data coming from self-reports on the Piers-Harris Children's Self-Concept Scale, where all students reporting improved "intellectual and school status" post group as compared to before group (Baker, 2000).

In further research on intervention, at a small Texas school teachers and administrators executed a group intervention with the goal of meeting student affective needs (Queen, 1994). The study involved twenty-seven students age thirteen to nineteen, entering a small alternative school in a metropolitan area of Texas. The students were administered a staff-created survey which was designed to briefly address student affect within the recent past (Queen, 1994). The anonymous survey asked the students several questions. The first question asked if the student had ever experienced any of the following symptoms: depression, lack of confidence, feeling left out, difficulty sleeping, frustration at home, frustration at school, drug use, alcohol use, or feeling unable to complete tasks. The second question asked what the student considered to be his/her greatest current problem, and the third question asked about student contact with police or juvenile authorities (with the exclusion of traffic tickets).

Initial survey results indicated that twenty students reported drug use, twenty students reported alcohol use, twenty-two reported self-esteem problems, twenty-two experienced

depression, and nineteen felt left out socially (Queen, 1994). Administrators and teachers coordinated and facilitated a semester long process group that met daily for thirty minutes at the onset of the academic day. Students were divided into groups of six to eight and used the group time to express their current needs and problems, and teachers facilitated student-directed problem solving and group processing. At the semester's end, students were given a post-intervention survey with the same questions presented in the pre-intervention survey. Three students reported using drugs, ten used alcohol, five reported low self-esteem, and four experienced depression. In Addition, a positive but unexpected benefit of the intervention was improved academic achievement (e.g., none of the students were failing any classes at the end of the semester), and truancy rates decreased from 80% the previous academic year to 50-65% during the semester where intervention was offered (Queen, 1994).

In another study, researchers found that an intervention involving systemic psychological support improved school attendance in school refusing students (Heyne et al, 2002; King et al, 2000). The researchers hypothesized that systemic support which provided cognitive behavioral therapy directly to the student (CBT-S), plus parent and teacher training (PTT) would produce better outcomes and more school attendance, than the support which provided only one or the other. Male and female students from seven to fourteen years old participated in the study, and mentally retarded and conduct-disordered students were excluded (Heyne et al, 2002).

The Heyne et al (2002) study divided subjects into three equal treatment groups: direct student therapy only, parent and teacher training only, and a combination of student therapy plus parent and teacher training. The CBT-S treatment consisted of eight,

fifty-minute therapy sessions with the student, the PTT treatment consisted likewise of eight, fifty-minute training sessions with the parents and teachers, the combination treatment combined both the CBT-S and the PTT treatments (Heyne et al, 2002). The pre-treatment measurement—which mapped onto the school refusers classified as avoidant and anxiety type school refusers in Evans (2000) study, plus in Kearney’s (2003) school refusal types—collected data on Generalized Fear, Fear of the Unknown, Psychic Stress, Medical Fears, Worry/Oversensitivity, Fear of Failure and Criticism, and Internalizing Behaviors; post-treatment measurements were collected immediately after treatment, and four and a half months later (Heyne et al, 2002)..

Results collected immediately after the treatment showed improvement in all three groups, but with the greatest improvement in the systemic, combination treatment group (CBT-S and PTT). At four and a half months post treatment, the combined effect of CBT-S and PTT leveled off, whereas the CBT-S-only and PTT-only group’s level of improvement stayed the same, leveling out the efficacy between treatments in the long term (Heyne et al., 2002).

Kearney (2001) has created a formal assessment tool for evaluating school refusal behavior called the School Refusal Assessment System (SRAS), which has since been revised (SRAS-R). SRAS-R has been used successfully for assessing risk and understanding the function of school refusal for students and guiding appropriate intervention strategies. For example, Dube and Orpinas (2009) studied the School Refusal Assessment System – Child (SRAS-C) in a non-clinical setting (the SRAS is traditionally used in clinical settings and not directly in schools).

In the Dube and Orpinas (2009) study, ninety-nine boys and girls, from grades three

to twelve (whom were not documented to have chronic health problems), were given the SRAS-C. The two research questions for this study were the following: (1) in a nonclinical population, does the SRAS-C result in profiles similar to what has previously been reported in clinical studies? and (2) if profiles are identified, do they correspond to meaningful differences in other areas that school social workers typically address, such as behavioral problems, victimization, aggression, and traumatic stress? (Dube & Orpinas, 2009).

The SRAS-C breaks down motivating factors and determinants of school refusal into the following profiles: negative reinforcement (avoidance of school), and positive reinforcement (parental attention). Three profiles were identified in the Dube and Orpinas (2009) study: 17.2% missed school to avoid fear- or anxiety-producing situations, escape from adverse social or evaluative situations, or gain positive tangible rewards (multiple profile); 60.6% missed school to gain parental attention or receive tangible rewards (positive reinforcement); and 22.2% had no profile. All three groups significantly differed in mean scores for behavioral difficulties, with children in the multiple profile group having the highest level of behavioral problems and children in the no profile group having the lowest level of behavioral problems. Although more studies are needed, these findings suggest that SRAS-C assessment might be effective in determining motivation for school refusal in non-clinical settings. Skillful use of this assessment in schools and problem-focused solutions aimed at alleviating the behavioral determinants of school refusal might be used to reduce school absenteeism in students who might otherwise follow a path that leads to school dropout.

Kittles and Atkinson (2009) looked at the efficacy of motivational interviewing (MI) as a therapeutic intervention for effecting behavior change in disaffected students, which

include school refusing students. Three students participated in the study, two girls and one boy, Emma (fourteen years old), Davina (thirteen years old), and Jacob (fifteen years old). The results of the study were measured using self-reports from the participants, and interviews with the teachers and parents of the students.

MI is a therapeutic technique with six stages (Kittles & Atkinson, 2009). The first stage is the *precontemplative* stage where the student sees no problem even though others disapprove of their behavior. The second stage is the *contemplative* stage where the student weighs the pros and cons of changing the target behavior. The third stage is the *preparation* stage where the student is getting ready for change. The fourth stage involves *active changing*, when the student puts the decision to change into practice. The fifth stage is the *maintenance* stage where the student is engaged in actively maintaining the change in behavior. The last stage, which could bring the student full circle (back to the targeted negative behavior), is *relapse* (Kittles & Atkinson, 2009).

MI therapy is different than solution focused therapy and cognitive behavioral therapy, because the process involves direct interviewing of the participant / student; however, it can be combined with CBT. In the Kittles and Atkinson (2009) study, Emma and Jacob were reported more verbally aware, had greater social competence, and had more motivation to move from the precontemplative stage to the contemplative stage so they fared better in the MI therapeutic model than Davina.

Regardless of prevention and intervention efforts, it is inevitable that some students will refuse to go to school and drop out. Research indicates that effective dropout recovery and student reentry programs are relationship-based, student-centered, and has a success-oriented model instead of discipline-oriented model (National Dropout Prevention

Center, 2011). In Addition, effective recovery programs create partnerships between schools, communities, social organizations, families, and students (Zammitt & Anderson-Ketchmark, 2011). The National Governor's association has compiled a list of effective strategies for increasing dropout recovery and reentry programs. One effective strategy is making a General Equivalency Diploma (GED) available for all students at sixteen years of age, and approximately half of all high school dropouts eventually earn a GED (Princiotta & Reyna, 2009). This is a useful strategy for graduating students; however, students with GEDs typically earn less than students who graduate from high school in four years with a high school diploma.

One idea for increasing the number of returning students is to offer incentives to schools who recover dropouts and school refusing students. Money is a strong motivator and funding needs to be available for such programs to be implemented at schools, and needs to be set aside by state or federal government for the purpose of rewarding student recovery. Many students drop out in their senior year, only a few credits away from graduating, and these students in particular should be a high priority for reentry or alternative academic programs (Princiotta & Reyna, 2009).

Texas employs the Reach Out to Dropouts system that offers a systems approach for recovering students, which involves district superintendants, volunteers, teachers, and school social workers and attendance workers making visits to disenfranchised youth and sharing meaningful academic alternatives to typical high school (Princiotta & Reyna, 2009). The Reach Out to Dropouts program has recovered more than 5,500 students in Houston since 2004 and increased high school completion rates by 10%. Another effective re-entry program highlighted in the National Governor's Report is Project U-Turn. This program's

operating model employs a one-stop service center for schools and offers an alternative curriculum (that meets state standards), academic support, access to community services, and alternative learning schedules (three hour blocks daily in the morning, afternoon, or evening). Project U-Turn monitors youth for readiness to re-enter a typical four-year high school to improve student outcomes and monitors students for four months after re-entry (Princiotta & Reyna, 2009).

A final prevention and intervention strategy is self-advocacy. Teaching students self-advocacy skills is an untapped and under-resourced area for prevention of school refusal behavior. Self-advocacy is an especially important proposition for students who already demonstrate risk factors that increase the likelihood that they will drop out of school before they graduate (e.g., students who receive special education services and students from low SES or minorities) (Weimer, 1994). Some of the reasons for school refusal—including learning difficulties, anxiety, affect dysregulation, and family stress—may be mitigated if schools create an environment that both encourages and teaches self-advocacy to students. Schools may choose to teach self-advocacy skills as a Tier 1 intervention for all students; however, special education classrooms would benefit from Tier 2 intervention even further. Repeated and more intensive instruction in self-advocacy skills would be especially appropriate for students who receive special education services.

School-based studies on the effects of self-advocacy training for students with disabilities indicate that teaching self-advocacy skills increases student involvement in the IEP process (Mishna et al, 2011). Direct instruction on self-advocacy involved providing students with their IEP and noting what kind of accommodations and modifications they were entitled to in accordance with their offer of free and appropriate public education

(FAPE). After role-playing and discussing accommodations, students were encouraged to bring this information to both special education teachers and general education teachers. After all instructional modules were completed in self-advocacy, almost immediately students started to bring their modifications to special education teachers and their special education case manager. Furthermore, within a few months, several students began to advocate for themselves within the general education classroom (Mishna et al, 2011). In Addition, case managers noted that students were experiencing increased success in personal relationships and in school work, suggesting that the self-advocacy skills were generalizing to other parts of school and other relationships (Mishna et al, 2011).

Other studies by Wehmeyer and Ward (in Malian & Nevin, 2002) indicate that direct instruction in self-advocacy lends itself to improved grades, improved personal relationships, and, by extension, greater success in college and in adulthood. There is a dearth of research related to self-advocacy as it relates to school refusal behavior and school drop out; however, it is reasonable to consider that self-advocacy can improve attendance, especially when the student is able to indicate why they are missing school, or why they are having increased emotionality surrounding school attendance.

Summary and Synthesis of Literature Review

Research supports development of the proposed project, as do informal interviews with professionals and specialists who work with children in their day-to-day responsibilities at schools. For example, statistics indicate that school refusal behavior, including dropout, poses a significant risk to individual students, their families, and imposes an enormous financial cost on society related to decreased employment, increased criminal activity and incarceration, and lower SES (National Education Association, 2006). Some researchers do not operationally define school dropout as a form of school refusal behavior, whereas others researchers include dropout under the umbrella of school refusal behaviors (Kearney, 2003). The researchers who couch dropout within the context of school-refusal typically look at school refusal as a continuum of behaviors that begin with a student attendance under duress accompanied by a desire to miss school (for reasons other than physical sickness) at the lowest end of the spectrum and drop-out at the highest end of the spectrum (Kearney, 2003). Studies were not able to provide quantitative correspondence between school refusal and eventual dropout; however, problematic absenteeism is almost always a precursor to dropout (Princiotta & Reyna, 2009).

A key problem in school refusal behavior is support. Schools have limited systemic support for identifying school refusal behavior, despite the fact that inattendance is part of the criterion considered when schools are reviewed for lack of adequate yearly progress (AYP). However, schools presently do not have available professional resources (e.g., school psychologists, PSA counselors, psychiatric social workers, teachers, and itinerant therapists) to attend to this problem, which occurs in approximately 5% of children (Kearney, 2003). Teachers are forced to re-teach or remediate for lost instruction when students demonstrate

school refusal behavior, which is a waste on resources already stretched thin.

School psychologists commit significant time to evaluating students who might best be treated more proactively, and expeditiously, with Tier 2 or Tier 3 school refusal interventions. School PSAs follow district or school protocols for attendance issues that are typically informed by punitive models of intervention (e.g., ACT), which is, in effect, a parental version of “scared straight” for school refusal behaviors. School psychiatric social workers typically only see students in accordance with Designated Instructional Services offered as part of the district offer of Free and Appropriate Public Education as defined by the student IEP. Most students who demonstrate school refusal behavior do not have an active IEP.

With some material supports, such as a treatment maps and manuals, readily available to streamline intervention, existing credentialed specialists (e.g., PSA counselors, school psychologists, psychiatric social workers, school counselor, and teachers) can offer support to this population of students, and their families. Treatment has been shown to be effective with decreasing problematic school absenteeism and, by proxy, the accompanying negative effects that school refusal has on the student, their family, the classroom, and the school in general.

Chapter 3 – Project Development and Implementation

Introduction

This project provides an alternative intervention for student services professionals who are qualified to deliver psychotherapeutic interventions to students. Specialists who are trained to intervene in school refusal behavior and assist with mitigating any accompanying student affect are typically not in a position to receive the necessary details in a timely fashion and deliver such an intervention. For example, at best, the school psychologist will be involved in intervening on students demonstrating disruptive school refusal behavior when such students are on campus, and when the behavior escalates to the point where the teacher feels that his/her expertise is exhausted. However, school psychologists are not likely to hear about student attendance issues until a SST is scheduled and PSA counselors provide data about specific students.

Research, and informal interviews with professionals within schools, indicates that a simple, well developed, targeted treatment plan would assist with increasing intervention and services to children demonstrating school refusal behavior (National Education Association, 2006). In schools, with budget cuts growing deeper year after year, professional staff is stretched thin, doing more with less. If an effective treatment protocol is available, and professionals do not need to commit their limited time to researching the appropriate treatment, they are more likely to deliver the services to students.

Project Development

Students who are often absent from school, or make frequent trips to the nurse's office, are not likely to hit administrative or teacher radar and be targeted for discipline or intervention, certainly not until the behavior becomes a habit, and the habit necessitates action on the part of the school. This pervasive attitude to see if things improve on their own, and the truth that all parties within the school are stretched thin—and are learning to do more with less (help, money, support) —is another manifestation of the “wait to fail” model in schools. In education, as in life, the squeaky wheel gets the grease. In much the same way that students with behavior problems and concurrent academic deficits will result in quicker referrals for psychoeducational assessment, students who demonstrate behavior problems who exhibit concurrent school refusal behaviors will also be referred more quickly. The referral, however, may go to the school psychologist, or disciplinary administrator (e.g., dean of students, vice principal, principal), with the targeted concern being behavioral problems instead of school refusal problems. There was limited research which offered a step-by-step analysis of what works for what students and why (Kearney, 2004; Wimmer, 2008). For example, there are studies that use extant data in order to find predictive variables for school refusal behavior (Rumberger & Lim, 2008; Reid, 2006; McShane et al, 20012; Hagborg & Masells, 1991). There are other studies where a small sample are offered interventions, usually anxiety-reducing treatment—targeted, effective treatment which include pre- and post- treatment assessments (Baker, 2000; Heyne et al, 2002; King et al, 2000).

School refusal is a complex and dynamic issue that involves student behavior, internal causal factors, family factors, learning factors, school factors and community factors

which increase or decrease the likelihood that the behavior will occur. In Addition, as the student interacts within his/her environment, reinforcing factors serve to support or inhibit future behavior. When queried informally, neither school administrators nor school psychologists had any in-school plan for supporting these students or helping their parents (personal communication, Dr. Tara Leufroy, May 2011; personal communication, Irma Herrera, January 2012). Individuals in both positions suggested that attendance messages and district outreach was the protocol for managing excessive absences. Both interviewees were unable to qualify the term “excessive absences”, however they did provide a quantitative threshold by indicating that excessive absences requires three or more consecutive days of absences.

This project began with the question related to an anecdotal situation. The questions became: When is it appropriate to offer services? Who at school is going to help these students? Who is going to help the students’ parents? How many absences are too many absences? What are some of the reasons why students refuse school? What is the best treatment protocol and how does a practitioner know that? Who is best qualified to offer treatment? How long should services continue?

Steps taken to explore these questions involved speaking with individuals within the field, researching journals for school refusal behavior, various determinants and correlates related to school refusal behavior, family systems theories, and systemic school renewal. The discovery process suggested that the problem and maintaining variables are complicated, systemic, and interdependent.

See appendix for completed project.

Intended Audience

The target population for the present project are school refusing students and, in small part, their parents and teachers. The treatment map and interventions can be adapted for counseling younger or older students. The treatment is gender neutral and can be used with males or females, however, the participating students will be referred due to school refusing behaviors that meet or exceed a specific number of absences, or a percentage of days absent to days present. Students who demonstrate significant emotional duress surrounding school attendance—as reported by administrators, teachers, or parents—may also be considered for the program due to the significant distress that is provoked in the student, teacher/s, parent/s and administration. Student attendance under duress is on the lower end of the continuum of school refusal behaviors. Behaviors that are present on the continuum put the student at-risk for escalation, and these students should be considered for treatment depending upon available school resources and the systems ecological distress.

Personal Qualifications

The intended audience for the present project is school psychologists, clinical counselors, marriage and family therapists, clinical psychologists, psychiatrists, pupil services and attendance specialists, psychiatric social workers, and interns in these same fields. Practitioners that are trained to offer social work, psychotherapy, or counseling, are appropriate persons for delivering the treatment, as are interns in these same fields so long as they are supervised by licensed practitioners. The project is designed to guide practice with students who refuse school. However, in addition to those who deliver the treatment, teachers and administrators would benefit from understanding the treatment plan for students who are receiving services either in school or outside of school. Students should be seen by their doctor to rule out any medical condition that would prevent the student from benefiting from treatment. It would be especially important for teachers to be involved in treatment as it relates to reinforcement of targeted behaviors, offering the student a prescribed area to cool off or calm down, and understanding the student's overall affect in order to better support his/her emotional needs as it effects his/her education. In addition, parents must be well-informed and trained, to some degree, in appropriate interactions, home interventions, and reinforcements which will encourage their child to enter school, with decreased distress, and tolerate attendance throughout each school day.

Environment and Equipment

The proposed intervention requires a room within the school that can accommodate individual students or groups of students (for group work) and their families and teachers. Depending upon the individual student's treatment, a comfortable room with non-classroom ambiance will be appropriate. In other cases, or at different times during treatment, an empty classroom might be appropriate for increasing student tolerance for anxiety. When possible, and as appropriate, the student's home or an outside therapy office, would be appropriate domains for intervention. The student's classroom is another area for intervention as the ultimate goal is for the student to attend school, for the full day, without marked distress, in his/her own classroom with their teacher/s and fellow students present. The equipment required for the intervention is the treatment map and intervention manual, which is to be used by the trained therapist, with different pieces or modules offered to parents and teacher as necessary and as directed by the service provider. In addition, the service provider will need to conduct interviews, obtain observations, and have a variety of formal social-emotional assessments such as the BASC, ASEBA, BASC, CDI, State-Trait Anxiety Inventory for Children.

Project Outline

The proposed project offers school based mental health workers a manual to guide practice in defining school refusal behavior, uncovering behavioral etiology, and offering targeted treatment according to the function of the school refusal behavior. Students will be identified using existing school attendance data and information available in school records. If students meet the identified level of school absences, the school will hold an SST to discuss the current absences. School record review will be an important component for determining whether treatment is an appropriate area of discussion at the SST meeting. Parental involvement in this meeting is very important.

In Addition, student involvement at meetings is important if the student is able to share some of the reasons that he is missing school. Parents will be interviewed during the SST, if possible, or provided with formal and informal assessments to return to school. According to student interview, parent interview, and teacher interview, record review, subsequent observations of the student in class and on the playground (if appropriate), and results of formal and informal assessments, treatment will be considered. If treatment is deemed appropriate by the parents, teacher, and school mental health administrator, it will be offered. Treatment will be guided by identifying the underlying etiology and function of the school refusal behavior. Appropriate treatment will be identified using several formal assessments (e.g. Child Depression Inventory-2nd Edition, Revised Children's Manifest Anxiety Scale-2nd Edition, Behavioral Assessment System for Children-2nd Edition, Achenbach System for Empirically Based Assessment, State-Trait Anxiety Inventory, and the School Refusal Assessment Scale), informal assessments including teacher, parent and student interviews, observations, and record review.

Four treatment options will be available for school youth, which are largely guided by the School Refusal Assessment Scale developed by Kearney and Silverman (2001). Students will be broken down into the following four groups: (1) School Refusal based on Avoidance of School Stimuli that Provoke Negative Affect, (2) School Refusal based upon Escape from Aversive Social or Evaluative Situations in School, (3) School Refusers who Seek Attention, and (4) School Refusers who seek Tangible Rewards Outside of School. A final, and well presented, typology exists as Mixed Type School Refusal. These students will be treated according to their most salient reason for refusing school. Service providers will be advised to offer treatment according to the primary function for the school refusal behavior and make appropriate accommodations for the treatment map by adding additional interventions in less salient areas.

For all students, treatment will be manualized in an effort to save time and effort on behalf of school-based mental health professionals. The treatment manual will suggest an eight to twelve week treatment for students in each of the four treatment groups. For students in the first two groups (anxiety-based school refusal), the treatment protocol will consist of psychoeducation around anxiety, cognitive restructuring using ABCs (antecedent-behavior-consequence), development of an anxiety or fear hierarchy, a feelings or fear thermometer, instruction in relaxation techniques, stepped imaginal exposure to situations listed in the anxiety/fear hierarchy, and stepped in-vivo exposure to situations listed in the anxiety/fear hierarchy. For students who demonstrate school refusal for attention-seeking purposes or to seek tangible rewards outside of school, treatment will involve parent training, contingency management at home and in schools, and behavior contracts with students.

Chapter 4 - Conclusion

Summary

School Refusal behavior is on a continuum of behaviors that begin with excused absences under duress and end, at the most extreme, with school dropout. As noted, school refusal creates short-term and long-term consequences. Short-term consequences include missing academic instruction, which affects grades, and creates missed opportunities to develop social skills with same age peers and non-familial adults, increasing overall levels of stress in their family of origin (or, alternatively, serve to provide dysfunctional homeostasis in their family of origin). More long-term consequences from extended school refusal are poor peer relationships, continued family stress, academic failure, and potentially dropping out of school all together.

School dropout poses an enormous financial impact on both individual families, and society at large. School dropout is positively correlated with an increased risk for unemployment, underemployment, incarceration, and reliance on social welfare. As Broffebrenner's (1979) ecological systems theory would suggest, several layers influence an individual's choices in life. For students, family systems, school systems, the larger community, and the student's personal attributes all contribute to providing risk or resiliency factors in the child's life as a student. At the level of the larger community, high levels of crime and lower socio-economic status are risk factors for increased school refusal behavior. At the level of schools, grade retention, and lack of coherent systemic response to school refusal, are risk factors for at-risk students. At the level of family systems, parental sickness or psychopathology, recent family changes (e.g., divorce, moving house, parental incarceration), dysfunctional family dynamics, low parental involvement at school, and

parental expectations (low versus high) contribute to increasing risk factors associated with school refusal. Intra-student factors that increase risk are low academic achievement, low involvement or investment at school (e.g., after school clubs, teacher affinity), student psychopathology (e.g., anxiety, depression), poor social skills, and student gender.

Efforts to retain and recover school refusing students are the school's responsibility. Most schools offer Tier 1, Universal preventative interventions to reduce school violence, decrease bullying, and foster social skills for the whole student body. Research indicates that poor social skills are positively correlated to increased risk for school refusal in addition to other negative consequences (Wimmer, 2008; Weimer, 1994; Kearney, 2001). In Addition, schools are legally obligated to direct efforts at recovering students who demonstrate significant school refusal behavior because school attendance is compulsory in the United States of America. An area of need, however, is Tier 2 interventions which direct resources toward students who begin to demonstrate school refusal behavior before students dropout, and before districts are mandated to begin legal action.

Evaluation

Three separate individuals who work in schools with students were consulted during the development of this paper and were evaluated regarding the potential usefulness of this project. The first individual is Mrs. Irma Herrera, M.S.W., a pupil services and attendance (PSA) counselor at Christopher Dena Elementary School. She has a master's degree in Social Work and she has been working in this capacity for twelve years. Mrs. Herrera works at two elementary schools within the Los Angeles Unified School District. She applauded the idea of taking a more pro-active approach to constructing a model for offering treatment and services to families, and directly to students, who demonstrate school refusal behavior. Another consultant, Mrs. Megan Thomas, who works as a PSA counselor at a single elementary school within the LAUSD, was instrumental in providing information regarding utilizing evidence based practices for students. She has a master's degree in social work and has worked for the LAUSD for over ten years and her consultation resulted in suggestions related to specific interventions for reducing student anxiety, and increasing both self-efficacy and communication for students. Finally, Dr. Tara Leufroy, a licensed clinical psychologist and school psychologist, was consulted in the creation of this project. She maintains a small part-time private practice, and she works full-time as a school psychologist within the Glendale Unified School District. She reviewed the present project and suggested that a manualized treatment would greatly increase the likelihood that a school psychologist, school counselor, or therapist would create the necessary time to intervene with this population of students. With regard to evaluating the final project, one school psychologist and three professional therapists who have worked with children inside or outside of the school setting were asked to review the project.

Bilingual School Psychologist and Nationally Certified School Psychologist, Ms. Carmen Ortiz, works within the LAUSD and has been a school psychologist for six years, and previous to her current position, she was a teacher for two years. On a Likert Scale from 1 (Strongly Agree) to 5 (Strongly Disagree), she *strongly agreed* that the manual would be helpful in offering student interventions, that the practices in the manual are evidence-based, and that ready-made worksheets would be helpful in working with both elementary school students and secondary students. She *agreed* that a treatment manual would increase the likelihood that any intervention would be offered to school refusing students, however, some responsibilities might need to be delegated to others within the school, or an outside agency, due to legally binding timelines related to student assessments. She commented that a manual was very helpful because it provided direction in treatment and it offered evidence-based practices for intervention. She affirmed that offering students appropriate interventions based upon the underlying causal factors which produce the school refusal behavior would be an effective method for guiding treatment. She had limited experience with imaginal exposure for anxiety treatment, but felt that it would be an appropriate treatment for individuals with anxiety. Ms. Ortiz stated that twelve weeks of treatment would likely be adequate to provide support, and encourage behavioral change, in students; however, attendance and affect would need to be monitored throughout the intervention and additional time might be needed depending upon each student's needs. She confirmed that parent training and contingency management would be very important in treating students with school refusal behavior, and most problematic behaviors, because parent buy-in is very important and it assists with creating consistency between school and home expectations. Also, Ms. Ortiz commented that student contracts are very useful for

most student behavior, with the caveat that the student must be invested in abiding by the terms of the contract. In Addition, she noted that successful student contracting may generalize to improved self-efficacy and self-advocacy for the student in the future.

Licensed Marriage and Family Therapist, Mrs. Rebecca Rufer, has worked as a Marriage and Family Therapist for six years. She has worked with foster youth and within schools providing therapy for students and parents. On a Likert Scale from 1 (Strongly Agree) to 5 (Strongly Disagree), Mrs. Rufer responded that she *strongly agreed* that that a manual would be helpful in offering school refusal interventions, and that a treatment manual would increase the likelihood that she would offer any intervention. She responded that she *agreed* that the practices in the manual were evidence-based practices, and that ready-made worksheets would be helpful in working with elementary and secondary school students. Ms. Rufer stated that an investigation of the underlying causes for student school refusal behavior was an appropriate starting point for intervention. She commented that, depending upon student anxiety, imaginal exposure may or may not be appropriate for increasing tolerance to distress over student attendance. She offered some insight about the 12 week intervention timeline, relating that she often had problems student and parent attendance for the first few sessions of therapy; she added that eventually, if the student and parent valued the service or intervention, attendance usually improved after the one month mark. She suggested that teaching students relaxation skills, included guided imagery and deep breathing exercises, should be one of the first interventions for students who engage in school refusal behavior in order to avoid anxiety or negative-affect because the skill is easy to learn and may increase student efficacy more quickly. She affirmed that parent training and contingency management would be an important part of the intervention, especially with

children, because it builds positive parent-child relationships. Ms. Rufer noted that student contracts would likely be beneficial in cases where the student was a stake-holder in the outcome, and that successful student contracting might serve to increase student self-efficacy in general.

Marriage and Family Intern, Penny Timmons, has worked as a marriage and family therapist part time for five years. She has worked with adolescents and families at a non-school based counseling center in Los Angeles. On a Likert Scale from 1 (Strongly Agree) to 5 (Strongly Disagree), Ms. Timmons responded that she *strongly agreed* that a manual would be helpful in offering intervention services to school refusing students, and that a manual would increase the likelihood that she would offer any intervention for this behavior. She responded that she *agreed* that the practices listed in the manual are evidence-based practices, and that the ready-made worksheets would be helpful in working with both elementary and secondary school students. She responded that the identification of underlying stressors, which support school refusal behavior, was an important part of the intervention because it informs the intervention strategy. She agreed that imaginal exposure was a necessary prerequisite for students prior to in-vivo exposure with regard to school attendance. Ms. Timmons did not feel that twelve weeks was adequate for the manualized intervention, however, she noted that some reduction in symptoms might be gained in twelve weeks. One suggestion for improving the treatment plan was to include additional counseling hours which are not guided by the intervention; instead the additional counseling hours would serve as a time to explore the student's home and school environment and student affect in general. Ms. Timmons felt that parent training and contingency management would be an important aspect of the intervention because consistency across

domains (school and home) will support behavioral change more effectively. She had limited experience with behavior contracts for students, and stated that such contracts might be effective for some students, but probably not all students.

Licensed Marriage and Family therapist, Joe Hobel, has worked as a marriage and family therapist part time for ten years. He has worked with adolescents and families at a non-school based counseling center in Los Angeles. On a Likert Scale from 1 (Strongly Agree) to 5 (Strongly Disagree), Mr. Hobel responded that he *strongly agreed* a manual would be helpful in offering interventions for school refusing students, that manualized treatment would increase the likelihood that any intervention would be offered, that the practices listed in the manual are evidence based, and that the ready-made worksheets are appropriate for elementary and secondary school students. He agreed that addressing underlying, causal factors which contribute to school refusal is a good starting point for addressing school refusal behavior. In Addition, he stated that imaginal exposure is a good starting point in exposing students to the feared or anxiety-provoking situations which support school refusal, and that refraining from flooding (e.g. strong, direct exposure to anxiety provoking situation which elicits a strong affect) would be important when working with children. Much like Ms. Timmons, Mr. Hobel did not feel that twelve weeks would be adequate for making significant improvements in school refusal behaviors. Suggested improvements to the intervention included sessions with parents for all school refusing types, as opposed to limiting parent sessions to school refusers who refuse to attend school in order to pursue more desirable activities outside of school, and adding family therapy sessions to all treatment plans. Mr. Hobel felt strongly that parental involvement should be an integral part of the treatment plan for all children because parenting practices are a key contributor in

influencing, supporting, or inhibiting behavior, including school refusal behavior.

Discussion and Conclusion

The panel provided the researcher with some additional information that was added to the end of the project in an area named “Considerations.” Information about potentially pre-existing truancy or school refusal prevention programs was added into the “Systemic Considerations” section of the project. Information about considering whether school-refusing students might be added into existing treatment groups that do not target school refusal behavior was added into the “Choosing Students” section of the project. Overall, the researcher discovered that a combination of limited school-based resources, plus school personnel’s level of professional overwhelm, are the biggest hurdles for offering this intervention. The single panel member who already offers counseling services to students found the manualized treatment to be helpful for informing practice, whereas the other panel members found the project to be potentially helpful; however, their responsibilities did not include counseling students. These panel members found the manualized treatment plan to be probably effective, but left the researcher with the sense that the current day-to-day flow of responsibility would leave them less than likely to offer these services.

Based upon the researcher’s knowledge of the presenting problem, the researcher feels that an in-service with administrators might be beneficial in reordering systemic priorities within the school, and potentially freeing up time for school-based mental health counselors and psychologist to offer intervention services to this population of students. It would be ideal to offer administration, at the school and district level, quantifiable financial information that would incentivize the delivery of this program for students. One cannot typically quantify a moving target; only when a student drops out as the end-point of school refusal, is the statistical information readily calculated into greater societal costs. In

Addition, the costs leading up to that final potential end-point are not always paid in dollars and cents; the costs are paid in tears by the personal burden placed on individual students and their families.

Future Work / Research

Most individual schools, and districts as a whole, do not develop holistic school-community partnerships to service individual students and the families of students. Wrap-around services that cover student's physical and mental health are sorely lacking in schools. Such services should be embedded into the fabric of schools, and meaningful community dialogue should occur within schools regarding this topic.

The present project can readily be used at schools with individuals who are willing to use the project to guide practice. The project offers a stand-alone treatment map for treating the school-refusing student population. For schools that typically contract with outside therapists to provide school-based counseling services, these contracted providers can and should be offered the present project. In terms of the efficacy of the intervention, the researcher would like the opportunity to collect quantitative data about student absences before and after treatment, provided that a district would be willing to share such data with the researcher. In Addition, the researcher would like the opportunity to view the pre- and post-treatment formal assessments and the goal attainment scale developed by the service provider to evaluate statistical significant around treatment efficacy. Ideally, it would be wonderful to have both student and family entrance and exit interviews; however, the likelihood that the service provider would be able to provide both pieces of data is very small.

Chapter 5 – Summary and Discussion

School refusal is an ill-defined behavior in schools. In Addition, most graduate school programs for school-based social workers, school psychologists, and school counselors do not prepare students for identifying this population of students in schools. This is an unfortunate misstep and an apparent gap in training school-based professionals. In training as in practice, neither quantitative nor qualitative criteria are suggested for providing behavioral or mental health services for this population of students. It is common knowledge that a drug addict doesn't change in one momentous event from a non-drug user to a full-blown addict. In the same way, initial school refusal behavior, when recognized, should be identified as a potential "gateway" behavior into the more perilous territory of school dropout. Best practices across psychological fields should indicate that early treatment and intervention delivers the best results. In Addition, at earlier stages on the school refusal continuum, with children attending school under significant duress and pleas for nonattendance, the anxiety around school attendance causes a significant intra-psychic stress in the student, and significant stress within the student's family.

School refusal, in the short term and over time, has non-psychological consequences as well. When students do not attend school, or when their mind is anxious while at school, they miss classroom instruction or have a diminished ability to attend to that instruction. This can have immediate consequences for the student's grades, which can serve to further exacerbate anxiety and increase school refusal. Other immediate and long-term consequences are diminished social contact with peers and non-parental adults. Limited social contact outside of the home can contribute to limited development of age-appropriate pro-social skills, which in turn can exacerbate student anxiety and increase school refusal.

Family relationships become strained when students exhibit school refusal behavior, and the behaviors manifest from, or are embedded in, dysfunctional family dynamics. Parents and caregivers bear the emotional burden of caring for a child in psychological pain. Parents also bear the financial burden of missing work to stay at home with the child if the child is young, and adolescents left on their own may, potentially, engage in delinquent activities.

School and societal financial consequences of non-dropout school refusal behavior are difficult to quantify because the behavior is a moving target; only once the student drops out of school are the financial consequences well documented. For students, their families, and their schools of attendance, making a commitment to direct time and money toward these students before their behavior becomes entrenched and self-sustaining is money well spent. For these students, the idea that “an ounce of prevention is worth a pound of cure” is a fitting adage.

Although school refusal is not always associated with mental health conditions, two of the functions of this behavior are associated with anxiety, which is a prevalent psychopathology in both American adults and teenagers. With that in mind, there is mounting scientific evidence to demonstrate the cost effectiveness of mental health prevention and treatment interventions. Many studies have demonstrated that mental health interventions for children and adolescents in school are not only beneficial for ameliorating some of the conditions for individual students and their families, but these interventions also provide financial benefits to society in general due to increased productivity in adulthood (Henry, Bales, & Graves, 2007). It is reasonable to assume that costs to individuals, families, and society will be reduced if impairment associated with mental health issues is decreased. Beyond childhood, adults with mental health conditions, especially depression,

anxiety, and conduct disorder, tend to require more health services and be unemployed or underemployed for most of their adult lives (Henry et al, 2007).

In the researcher's school-based experience, corroborated by informal interviews with a school psychologist and school-based social workers, programs exist at the school and district level to help reduce the growing number of school dropouts; however, few exist that effectively help students when they begin to demonstrate school refusal behavior. These school-based professionals are not typically directed to offer services which would address underlying problems which manifest in school refusal, rather, they are directed to follow district procedures which typically employ a stick, rather than a carrot, to elicit parental cooperation. The existing programs which are designed to address school refusal behaviors in their earlier, less entrenched, stage, specifically ACT, are designed to educate parents about their responsibility to facilitate compulsory attendance for their child. Parents are further educated about their culpability in their child's school refusal behavior, specifically about the significant legal consequences which may befall them should they not mitigate the existing school refusal problem.

Providing psychoeducation and behavioral training to parents and psychoeducation and treatment to students would address the function of the behavior. According to behavioral theory, behaviors are communications and serve to provide individuals with an opportunity to gain attention, escape undesirable tasks/emotions, gain access to tangible items, and provide sensory stimulation. In the case of school refusing students, their behavior can serve three of the four listed functions. A functional analysis of their behavior, like other behaviors in school that rise to the level of requiring a functional behavioral analysis, is appropriate to direct treatment for this specific behavior.

Informal interviews and research in-school experience parallel the results of Bramlett, Murphy, Johnson, Wallingsford, and Hall's (2002) study that quantifies and qualifies how school psychologists spend their time in schools. Their study indicated that school psychologists spend 8% of their time offering counseling services to students and 1% of their time offering parent training (Bramlett et al, 2002). If other mental health research indicates that time spent offering evidenced-based psychological treatment is cost effective and offers long-term financial benefits to individuals and society at large (Henry et al, 2007), it might be prudent for school psychologists, and school mental health professionals in general, to consider increasing counseling services to students.

Perhaps the efficacy of student counseling and parent training will be evidenced in decreased need for other roles and functions, currently reported at 46% of time spent in assessment, and 1% of their time doing research (Bramlett et al, 2002). Many school psychologists report a preference for direct interventions and counseling with students, in fact, those activities were often the catalyst for initial entry into the field; however, when placed in schools, inadequate time is the greatest obstacle for offering those same services (Bramlett et al, 2002). If school psychologists, or school mental health professionals did not bear the burden for conducting research for effective, research-based interventions, they could increase their time spent counseling students.

A ready-made manual and treatment map might provide a bridge between their desire to offer counseling to students and their limited time to devise appropriate treatment strategies. In Addition, offering counseling services and parent training to school refusing students and their guardians may reduce assessment loads. This is significant when almost half of school psychologists' time is spent on assessment. The potential for decreased

assessments is tied to increased student presence at school, both in the physical sense (i.e. the student is not absent), and in the mental/emotional sense (i.e. attention to classroom instruction increases as anxiety decreases). Most assessment referrals are tied to lack of academic achievement services (Bramlett et al, 2002), and achievement is directly related to time-on-task in the classroom, which is supported by attention to instruction.

Three separate school mental health professionals, one doctorate level school psychologist, and two pupil services and attendance counselors with masters degrees in social work, were consulted during the development of this project, and after the treatment manual was finalized. All consultants addressed their lack of time, in general, and as it relates to adding an additional student service to their already full day. However, all consultants felt that the project would be a useful tool in their student services arsenal. Besides lack of time, the consultants referred to current school policy and the lack of a uniform protocol for students with excessive absences. The school psychologist confirmed that she very rarely offered school-based counseling, and that she almost never consulted with staff or parents regarding excessive student absences. The school based attendance counselors had some concerns about existing programs for students who have many school absences; they were unfamiliar with the term “school refusal” and did not deliver services to students or parents according to their skill-set (social work), rather relying on the existing system in place, which penalizes parents for their failure to facilitate school attendance for their children.

One consultant, who had a larger counseling caseload, suggested that school-refusing students could be fit into existing groups according to their presenting etiology and/or the function of their school refusing behavior. She also suggested that parents of these children

should be targeted for existing in-services on parent-assertiveness training (e.g. Back In Control) and contingency training. All parties reported that a ready-made manual would encourage them to offer services to this student population. In Addition, the consultants stated that the treatment map and decision tree would increase the likelihood that the principal and assistant principal would lend systemic support to this service.

Overall, the researcher discovered that school refusal is not a well understood behavior for school mental health professionals. Dissemination of the project might be best coupled with professional development presentations offered to both school mental health professionals and school administration. To increase the likelihood of buy-in for administration at the school and district level, future research should focus quantifying actual financial gains and losses by way of calculating student retention, decreased assessment loads, state and federal monies retained by increasing student attendance, decreased staff expenditures surrounding student absences, decreased SART and SARB involvement, decreased expenditures for counsel and lawyers related to absences, and losses of students. This kind of concrete financial information would incentivize the delivery of effective services to students who demonstrate school refusal behavior. The project might be improved by adding modules that are developmentally appropriate for students at different ages. In Addition, it would be useful to have student demographics, pre-treatment, and post-treatment data from students who participated in treatment. It would be beneficial to tailor the treatment manual, in the future, to special populations if data shows that different treatments are especially useful with different populations.

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School Refusal Behavior:
A Treatment Map and Manual for
School Psychologists, School Counselors,
Therapists and Pupil Services Professionals

By: Tonya Claycomb

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* Do not copy SRAS materials from manual. Forms available in the following book or online at Oxford University Press using the web address listed below:

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Statement of Need

In my professional experience as a school psychology fieldworker, school psychology intern, and in my personal experience as a parent of three school-aged children, I have found that school refusal behavior is a poorly understood behavior. At the level of individual schools, each school has a different protocol for handling absences. Informal interviews with school psychologists and school counselors in the Los Angeles Unified School District (LAUSD), the Glendale Unified School District (GUSD), and the Pasadena Unified School District (PUSD) reveal varied and, often, discordant protocols in place to deal with pupil attendance, whether the attendance is related to student illness, family factors, or school refusal. This lack of consistent, common nomenclature, and lack of a consistent protocol for handling student absences, within districts, and between districts, is a persistent theme in both research literature and the day-to-day activities of school professionals who may be in a position to intervene with students exhibiting this behavior (Kearney, 2003). Without consistent nomenclature, and consistent response, effective treatment for students and effective school wide and district wide policies will remain elusive.

Often school refusal is a manifestation of a child's anxiety or negative affect, whereas for other students it's a function of their desire to engage in other preferred activities, and often times, it's a combination of the two. Many school districts within Southern California hire professionals for the purpose of handling student attendance issues. One such position, within Southern California school districts, is a specialized school counselor whose specific focus is student attendance (the Pupil Services and Attendance (PSA) counselor); unfortunately, the job description, as posted on the LAUSD website, does not provide for counseling services for students or parents in order to mitigate of attendance problems. Instead, a PSA counselor is

responsible for creating a comprehensive school wide attendance plan, taking daily attendance, clearing excused and unexcused absences, notifying parents and guardians of unexcused absences or trancies, and facilitating enrollment and check-out of students but only rarely is able to consult with the school psychologist regarding school refusal, school anxiety, or inattendance, not to mention those acts of truancy that may not be reported to the PSA counselor.

If the PSA counselor does not offer counseling to students, or to parents, when a student begins to demonstrate school refusal behavior, there are other professionals within schools, such as the school psychologist or the (non-PSA) school counselor who have the appropriate skill-set (counseling, behavior intervention, parent training) and could offer services to school refusing students and their parents for the purpose of reducing absences. In Southern California districts, neither the school psychologist nor the school counselor is usually involved in offering interventions to school refusing students. If the PSA counselor, the school counselor, and the school psychologist are not assigned the responsibility to offer early, effective services to these students, then the student is likely to continue the behavior. Granted, sometimes the behavior remits spontaneously, but early, effective intervention is the gold standard for behavioral problems and psychological problems.

Some schools or districts have a School Attendance Review Team (SART) for problem-solving attendance issues within the school, and others may also have some pre-referral interventions in place. The California Department of Education (CDE) (2011) has a SARB review board where schools can be recommended for commendation with regard to their school attendance policy. The criteria for receiving commendation are broken down into ten content areas, the most important of which is area six which includes the prevention, early intervention, and intervention areas prior to SARB referral. It is unfortunate that the CDE recognizes

prevention of absences as an important part of supporting student attendance, yet districts, schools, and professionals therein are not trained, not even informed, about the importance of dedicating time and funds in toward these activities (2011).

According to informal interviews conducted with individuals working in local school districts, the CDE website, and local school district literature, prevention of school attendance problems is an area of weakness. For example, the Ventura County SARB Manual (2004) suggests that early intervention steps are critical and often overlooked. These steps should be developed by the SST or SART team, which includes the school nurse, school psychologist, school counselor, administrator, parents and the student, and should target the causal reason for the absences in addition to providing both positive and negative reinforcements and punishments to encourage correction. Unfortunately, neither the CDE nor any local SARB policy available for online public viewing has a clear and specific protocol and treatment plan.

Moving beyond prevention, schools often have a limited and latent response to student absences. For example, when student absences meet the high bar set by individual schools for problematic absenteeism, pupil service professionals within the schools are typically ill equipped and untrained to deal effectively with this problematic behavior (Kearney, 2003). Service professionals are not aware of the appropriate and effective research-based interventions available, and they have little understanding of the function of the behavior to begin with (Kearney, 2001).

The Partnership for Families and Children (2004) has looked at effective truancy prevention models and discovered a set of criteria that they believe to be mandatory for intervention efficacy. These criteria include parent or guardian involvement, a continuum of services including incentives, consequences and targeted supports, collaboration with community

resources including law enforcement, mental health, social services and mentoring, and school building components which ensure students have access to curriculum and ongoing evaluation. The Wilder Research Center (2003) reviewed the efficacy of several school refusal and truancy programs. Wilder's research agreed with the Partnership for Families and Children regarding the criteria for an effective truancy prevention program. The National Association of School Psychologists (NASP) recommends many of the same practices for effective parenting (n.d.). I suggest that trained professionals within the schools should consider creating proactive criteria for identifying students who are at-risk of escalating school refusal behavior, and these criteria should be vetted through school administration on the school level or at the district level (Ventura County SARB, 2004). School based professionals should be an integral part of delivering interventions to at-risk students, or they should be referred to outside professionals who would be willing to follow an evidence-based protocol for treatment (Costin & Chambers, 2007; King, Tonge, Heyne & Ollendick, 2000). The purpose of this project is, in small part, to encourage development of a protocol for identifying students who may be at-risk for developing school refusal behaviors, and, in large part, offering evidence-based interventions for treating students who are already engaged this behavior. Unfortunately, presently, in many local districts, even when student absences meet the high bar set by individual schools for problematic absenteeism, pupil service professionals within the schools are typically ill equipped and untrained to deal effectively with this problematic behavior (Wilder Research Center, 2003). In response to this vacuum, this project proposes a treatment map that will provide suggested criteria for defining school refusal behavior qualitatively and quantitatively. Formal and informal assessments aimed at determining causal elements and determinants for school refusal behavior will be suggested. In Addition, the project will assist pupil service professionals with

selecting appropriate, evidence-based Tier 2 and Tier 3 interventions for school refusing students according to the student's functional, or pathological, profile.

Systemic Considerations

Informal interviews with school psychologists and school counselors within three local districts reveal varied and incoherent systems in place to deal with pupil attendance. This incoherent response to school refusing students is exacerbated by a lack of common language for the phenomenon and varying responses qualitative (excused versus unexcused absences) and quantitative measures (e.g. days absent, tardy counts). And when school based professionals cannot communicate effectively within schools, or at the district level, students will suffer.

Regarding student attendance, California districts employ a school attendance review board (SARB) model in dealing with excessive students absences. California SARB breaks down appropriate responses to school refusal into ten content areas. The highest weighted content area is Area 6 which contains the area of prevention, early intervention, and interventions prior to SARB referral (CDE, 2011). In my experience, this is the greatest area of weakness in local schools relative to SARB's suggestions for best practices. Most professionals within schools are left without structural support in identifying students who might benefit from services in the area of prevention, early intervention, and intervention. Local districts within Southern California do not have well developed protocols for identifying at-risk students, and at the structural level, student services professionals, who might deliver services to students, are not able to make meaningful decisions about the when and where, and why and how of treatment for these students because protocols and directives are not in place at the administration level within schools and at districts (CDE, 2011).

Service providers should sit down and speak with the administration, especially the principal and vice principal, about prioritizing this intervention. Typically, school refusing children, excluding partial day absences or period-specific truancy, make up 5% of daily

absences. When combined with partial day absences and tardies, this percentage goes as high as 28% across all grades (Kearney, 2001; Kearney, 2003).

School refusal behavior is on a continuum (Kearney, 2001). School systems need to decide which students to target. It's important for school mental health and administration to recognize the behavioral continuum (below).

Level	Level	Level	Level	Level	Level	Level
1	2	3	4	5	6	7
School Attendance Under Duress and Pleas for attendance	Repeated misbehaviors in the morning to avoid school attendance	Repeated tardiness in the morning followed by with mixed nonattendance	Periodic absences or skipping of classes portion of the school year	Repeated absences or skipping of classes extended period of time	Complete absence during certain period of time	Complete absence from school for an extended period of time

It's critical for school systems, in collaboration with school mental health professionals, to choose which part of the continuum meets the minimum standard for considering intervention.

In Addition, administration needs to set quantitative criterion in deciding which children may be offered intervention. Often, spontaneous, brief episodes of school refusal, with Level 1 to Level 4 behaviors lasting for two to three weeks, resolve without formal, school-based intervention (Kearney, 2001). When a student engages in Level 1 to Level 5 behaviors, for a period of more than three weeks, it is considered moderate school refusal behavior, and Pupil Service and Attendance professionals should consider engaging in more assertive intervention with the student and parents. When a student engages in Level 1 to Level 7 behaviors, for a period of more than one month, a full intervention should be considered.

In Addition, schools must consider whether treatment is appropriate for students who demonstrate legitimate physical ailments, especially chronic conditions such as asthma, autoimmune disorders such as mononucleosis ("mono"), and various Epstein Barr viruses (Setzer

& Salzhaauer, 2001). Schools must also consider that students who present with school refusal behavior may have concomitant psychiatric diagnoses. Deciding upon whether to include or exclude this special population from intervention is an important programmatic issue for administrators and school based mental health professionals to discuss. To error on the side of safety and concern, it's best to use a functional analysis to tease apart the causal factors and offer appropriate services accordingly instead of excluding students simply based upon complicating medical or psychological conditions (Kearney, 2001).

Other students present with significant family issues which prevent them from coming to school or encourage absences (Kearney & Silverman, 1995). For example, some families are homeless and school attendance becomes a significant logistical issue. Other families have significant physical or mental health impairments which (seemingly) necessitate that the student stays home to care for a parent or older caregiver.

In Addition, each school needs to evaluate their human resources and available specialists to administer interventions to school refusers (Kearney, 2003). Best practices would suggest that offering targeted, empirically-based treatment, early (moderate level) rather than late is the most appropriate protocol. If school resources allow, students who demonstrate an absence rate of 25% (full days) for a period of one month, or those who demonstrate an absence rate of 10-15% (full days) in addition to 25% or more tardies, or partial-day absences should be investigated at SST (Student Study Team) monthly meetings.

Qualified Personnel

Interventions which require cognitive behavioral therapy and behavioral therapy should be offered by professionals licensed in counseling, social work, or psychology such as school psychologists, school counselors, marriage and family counselors, clinical counselors, psychologists or social workers, or interns in these same fields (Kittles & Atkinson, 2009; Malian & Nevin, 2002; King et al, 2000).

Process groups can be an effective supplement to intervention. These groups can be facilitated by licensed counselors, or interns, as above, or can be lead by student facilitators with a teacher or administrator acting as the adult facilitator (Wilder Research Center, 2003).

Teachers are, by necessity, part of the treatment plan when treatment involves in-class interventions including rewards or punishments (Kearney, 2001). Teachers can also provide nurturance and support for non-academic, non-behavioral interventions. Parent support is also necessary (Wilder Research Center, 2003; Partnership for Families and Children, 2003). Parental support and reinforcement of school interventions, and participation in parent training or family therapy, greatly increases the chances for decreased school refusal behavior (Costin & Chambers, 2007; Kearney, 2003; Kearney, 2008). With appropriate intervention, a family system that supports school refusal behavior can be effectively modified to hinder that behavior (Parents in Control, 2009; Barkley, Edwards, Laneri, Fletcher & Metevia, 2001; Partnership for Families and Children, 2003)). The term service providers and practitioners will be used interchangeably throughout this manual.

Choosing Students

As discussed in the Systemic Considerations portion of this manual, school refusal behavior is on a continuum. Research indicates that spontaneous, brief episodes of school refusal, often resolve on their own, without any intervention outside of the typical school-based protocol of calling parents when their child is absent (Kearney, 2001). If student absences continue for two to three weeks, the student might be demonstrating a more worrisome level of school refusal behavior. Moderate school refusal will be defined as the presence of student behaviors from Level 1 to Level 5, occurring for a period of more than three weeks. Whereas, Intensive school refusal will be defined as the presence of students behaviors from Level 1 through Level 7, occurring for a period of more than one month.

Students who demonstrate an absence rate of 25% (full days) for a period of one month, or those who demonstrate an absence rate of 10-15% (full days) in addition to 25% or more tardies, or partial-day absences should be investigated at a SST (Student Study Team) meeting monthly. A RIO (record review, interview, observation) model of investigation should be employed. Formal and informal tests will be administered after the RIO investigation after or during the SST.

Record review should occur before the SST meeting, and interviews with parent and teacher should be conducted within the context of the SST meeting. Records should be reviewed with a focus on the presence of absence of risk-factors which increase or decrease the likelihood that school refusal will continue. Risk-factors include previous episodes of school refusal (e.g. above average absences, unexcused by a physician, and excused or unexcused by parent or caregiver), a recent change in the family such as a recent move, a recent divorce, recent

parental or sibling incarceration, or parental illness, the transition between elementary and middle school, or between middle school and high school. If the record review reveals the presence of one or more risk factors, parents and students should complete the School Refusal Assessment Scale (SRAS) during the SST or agree to return the document/s to school at a date in near future.

Best practice suggests that treatments that offer the greatest efficacy should be offered first (Wilder Research Center, 2003; Ventura County SARB, 2004; Seltzer & Salzhauer, 2001; CDE, 2011). Student and parent forms that meet the SRAS cutoff for school refusal due to anxiety or negative-affect (Avoiders of School Stimuli that Provoke negative Affect, and Escapers of Aversive Social and Evaluative Situations) should be considered for treatment first. Student and parent forms that meet the SRAS cutoff for school refusal due to Attention-Seeking behavior should be considered next, and School Refusal due to Seeking Tangible Rewards Outside of School should be considered last (Kearney, 2001). If possible, parents and students who meet the minimum cutoff for Attention Seeking or Seeking Tangible Rewards, should be offered evidence based interventions at Tier 1 or Tier 2 such as Triple P Positive Parenting Program, The Incredible Years, and Parenting with Love and Limits (Kearney, 2003; Kearney, 2008; NASP, n.d.).

Students with contagious medical conditions should be excluded from intervention. This population of students should be referred to their doctor for medical and social-emotional support as needed. If the student's doctor is unable to provide appropriate medical or psychological referrals, school mental health, or the school based service provider should refer the student to appropriate resources. Please see the section "Medical Clearance" for additional details.

Students with special life circumstances such as homelessness should be considered for treatment only after their basic needs are met. Maslow theorized that lower order needs must be met before higher order needs. Food, shelter and safety fall within the bottom two need groups (physiological needs such as food and shelter, and safety needs). The families of these students should be offered outside resources to assist them with meeting their basic needs including shelter, food and safety. These students, especially, should be monitored carefully for increasing or consistent school refusal behaviors because they present with many risk factors which increase the likelihood that their school refusal will end with dropout (Kearney, 2001; Kearney & Silverman, 1995).

Record Review

School records should be reviewed for the presence of risk factors which may contribute to school refusal behavior. For example, the school psychologists, attendance counselors, counselors, or school mental health workers should review attendance records, when the student started at the present school, changes in family of origin that are present in school records (e.g. a recent divorce may produce custody change records; recent involvement with child protective services, parental restraining orders), changes in placement within the school from a general education classroom to a special day classroom, changes in services which are informed by recent IEP changes indicating increased or decreased resource support, teacher comments in cumulative record or report cards related to social-emotional weaknesses or academic weaknesses, unexpectedly slow progress in one or more academic areas as indicated by academic marks / grades, unexpectedly slow progress in language acquisition as indicated by English Language Level and/or formalized English Language Level Development Tests (e.g. California English Language Development Test, in California), Student Study Team (SST) meeting minutes, or parent or teacher notes addressing academic and social-emotional areas of need (Kearney, 2001). Changes in school, especially those that occur during the transition from elementary school to middle (or junior high) school, or the transition from middle school to high school are times when school refusal behavior tends to increase so school-based service providers should pay special attention to these transitional periods (Kearney, 2001). The presence of many risk-factors in school records, combined with meeting a minimum number of absences, indicates that a student should be reviewed during an SST or COST meeting and considered for intervention.

Medical Clearance

In all cases of school refusal behavior identified for intervention, students should be examined by their medical doctor to rule out underlying problems which may exclude them from treatment such as contagious diseases . In Addition, parents and doctor may wish to consider psychopharmacological intervention for the student in cases of depression, extremely anxiety, bipolar disorder, and the like, either as a supplement to intervention, or instead of intervention. In all cases, best practice would dictate doctor approval for identified students, however, this may be unrealistic for many students.

Students with medical conditions which prevent them from coming to school (e.g. contagious diseases such as mononucleosis, meningitis, hepatitis, etc.) should be ineligible for treatment due to the contagious nature of their condition. Parents should be apprised of alternative school settings for these students including independent study, itinerant teachers, and hospital school to ensure that the student does not fall too far behind academically. In Addition, in these circumstances, parents should be offered basic psychoeducation regarding the increased risk that their child/student will demonstrate school refusal behavior upon returning to school after an extended absence. When psychoeducation is coupled with small amount of parent training, it provide parents with an opportunity to be prepared for any distressing behavior that a student might engage in when s/he returns to school (NASP, n.d.; Partnership for Families and Children, 2003; Setzer & Salzhauser, 2001). Parents and service providers at school, or practitioners outside of school, can a supportive team for the as s/he transitions back into school.

Other students who present with school refusal behavior due to non-contagious physical illness or mental illness should not be excluded from treatment. Rather, these students who

demonstrate school refusal behavior with comorbid mental illness should be at the top of the list for treatment. In all cases, intervention should be should be informed by the function of the behavior (Kearney, 2001).

Parent Interview, Observations, and Assessment

Parents need to be interviewed during the SST or COST meeting or at another time. Service providers will need to obtain information about the student's attendance history that is not available in school records, such as the parent's perceptions about their child's absences. The parent interview should assess parent's perception of student's overall affect (depressed, anxious, attention seeking, avoidance of difficult tasks, socially anxious, difficulty making transitions), family dynamics at home including parental level of control, parenting style (authoritarian, authoritative, permissive, neglectful), recent changes at home (death, illness, moving house, divorce, new job, newly jobless, etc.), history of child oppositional behavior, parental psychopathology, parental history of anxiety disorders, and history of parental alcohol or drug use (Kearney, 2001, p. 55). Parents should be informed that the SST team is or is not considering intervention. If the team wishes to proceed with considering intervention, parents need to complete the Behavioral Observation for School Refusal Behavior form provided in the appendix of the manual (Kearney, 2001).

In Addition, parents who indicate that their child has significant generalized anxiety, social phobia, or social anxiety should be given a broad band or narrow band standardized assessment (e.g. State-Trait Anxiety Inventory for Children, Revised Children's Manifest Anxiety Scale-2nd Edition, Behavior Assessment System for Children – 2nd Edition, Achenbach Child Behavior Checklist, Beck Anxiety Inventory). If a parent indicates that their child exhibits significant depression symptoms, without suicidal ideation, they should be given an appropriate depression inventory (e.g. Child Depression Inventory – 2nd Edition, Beck Depression Inventory for Youth). With respect to examiner qualifications and competency with individual instruments, and varied instrument availability within schools, this manual will not

advise use of specific tools (except for the School Refusal Assessment Scale). Best practice would dictate that formal assessment tools in a specific area of concern, such as anxiety, or depression, is an appropriate measure for gathering measurable baseline data which can be later compared with measurable post-intervention data. For practitioners who are not qualified to use such instruments to obtain baseline (pre-intervention) data, a basic social-emotional interview with some targeted scaling questions (e.g. Likert scale questions) will give adequate baseline data.

In addition to the non-exhaustive list of formal assessments (above), parents should complete a School Refusal Assessment Scale – Parent Form in order to identify the etiology of the school refusal behavior. Results from the SRAS can be cross-referenced with other formal assessments to support appropriate intervention (Kearney, 2001). The School Refusal Assessment Scale identifies four separate functions for school refusal behavior. School Refusal Assessment Scale forms are provided in the appendix of the manual, however, they should not be copied. The forms are available without copyright by buying the Christopher Kearney book, *School Refusal Behavior in Youth: A Functional Approach to Assessment and Treatment*, or obtaining the form online at no cost at http://www.oup.com/us/companion.websites/9780195320244/tools/pdf/supplemental_tools1.pdf. Directions for calculating the results of the School Refusal Assessment Scale are listed in the appendix.

Child (Student) Interview, Observations, and Assessment

As part of the information gathering stage, the student needs to be interviewed. This can occur during the SST or sometime thereafter. Parental consent is required and the parents may need to be present depending upon the child's developmental age and level of anxiety. However, it may be more useful to interview the child separately if the practitioner suspects that the function of the child's school refusal behavior is parental attention or to pursue tangible rewards outside of school. Depending upon the family's level of cohesion, parents may be resistant to hearing that their reactions to their child's behavior make them complicit in supporting the continuation of the behavior (Setzer & Salzhauer, 2001; Kearney & Silverman, 1995). If the child demonstrates significant social anxiety with the otherwise unknown practitioner, the parents may need to be present, and this provides important observational data for the practitioner.

The student interview should assess student's perceptions of their parent's needs for assistance, parental anxiety, the presence of illness within the family, family dynamics, and student locus of control. Queries regarding student's perception of parenting style (authoritarian, authoritative, permissive, neglectful), recent changes at home (death, illness, moving house, divorce, new job, newly jobless, etc.), student's behavior as it relates to chores, daily schedules, and parent's expectations should also be addressed (Kearney, 2001).

The practitioner should request that the student complete the Behavioral Observation for School Refusal Behavior form provided in the appendix of the manual if the student is demonstrates developmental competence for the task. If the student refuses, or the form is not completed as requested, this provides additional information which may assist with informing

treatment during the manualized intervention .

In Addition, students who indicate significant overall anxiety, social anxiety, or depression should be administered an appropriate child or adolescent version of a broad and/or narrow band anxiety scales or inventories (e.g. State-Trait Anxiety Inventory for Children, Revised Children’s Manifest Anxiety Scale-2nd Edition, Behavior Assessment System for Children – 2nd Edition, Achenbach Child Behavior Checklist, Beck Anxiety Inventory). Students who indicate or exhibiting significant depression symptoms, without suicidal ideation, should be given an appropriate, standardized depression inventory (e.g. Child Depression Inventory – 2nd Edition, Beck Depression Inventory for Youth). If the student indicates pathology related to social anxiety, the service provider should administer appropriate formal assessment in that area (e.g. State-Trait Anxiety Inventory, Social Phobia and Anxiety Inventory for Children) (Kearney, 2001).

In addition to the non-exhaustive list of formal assessments (above), the student should complete a School Refusal Assessment Scale – Student Form in order to assess the underlying etiology and the function of the behavior. Much like the parent form, The School Refusal Assessment Scale- Student Form identifies four separate functions for school refusal behavior. School Refusal Assessment Scale forms are provided in the appendix of the manual but should not be copied. The forms are available without copyright by buying the Christopher Kearney book, *School Refusal Behavior in Youth: A Functional Approach to Assessment and Treatment*, or obtaining the form online at no cost at [http://www.oup.com/us/companion.websites/9780195320244/tools/pdf/supplemental tools1.pdf](http://www.oup.com/us/companion.websites/9780195320244/tools/pdf/supplemental%20tools1.pdf). Directions for calculating the results of the School Refusal Assessment Scale are listed in the appendix.

Teacher Interview, Observations, and Assessment

Before the initial COST or SST meeting, the student's teacher will need to collect data and/or provide preliminary information regarding student affect, student absences, and his personal impressions of the student. For example, the teacher can inform the team that the student has shown a pattern of absences on days where the class has a scheduled spelling test, or math test, oral report, physical activity, or team activity. This information can play a critical role in determining the function of the school refusal behavior (Kearney, 2001; Setzer & Salzhauer, 2001; Wilder Research Center, 2003). In Addition, the teacher can indicate a history of extended bathroom trips, or visits to the school nurses office when this data is not always available, or accurate, in school records. A teacher will readily notice patterns in a student's absences such as an increased incidence of absences on Mondays, after school vacations (e.g. Spring break, Winter break, 3-day weekends such as occur with President's Day), after personal vacations (non-school directed). In Addition, the teacher should provide data, quantitative and qualitative, with respect to his/her perception of what decreases the likelihood of school refusal behavior. Teacher should also provide information regarding the student's performance across subjects, and the level of teacher or peer support required for student success (or merely access) across subjects (Kearney, 2001). Special consideration should be given to students who demonstrate significant academic difficulty, and other school professionals (resource teacher, assistants to the resource teacher, peer partners, teacher assistants) should be encouraged to offer academic support, either with or without the presence of an IEP, and always with parent permission (CDE, 2011).

In Addition, teachers should be given targeted narrow-band assessments related to student anxiety, social anxiety, fear, or depression plus broad-band assessments related to

teacher's overall impressions and perceptions of the student (e.g. Revised Children's Manifest Anxiety Scale-2nd Edition, Behavior Assessment System for Children – 2nd Edition, Achenbach Teacher Report Form, Child Depression Inventory) (Kearney, 2001).

Functional Assessment & Etiology Identification

The service provider should assemble the results of the narrow-band assessments, broad band assessments, School Refusal Assessment Scales, interviews, and observation forms from teacher, parents and student to determine a probable function for the student's school refusal behavior. The School Refusal Assessment Scale (SRAS) provides valence for the different types of school refusal behavior: Escape from Negative Affect, Escape from Aversive Social or Evaluative Situations, Attention Seeking Behavior, and Positive Tangible Reinforcement. The results from student and parent SRAS scales should also be averaged together (see instructions in the appendix). It is common for the averaged results to indicate several significant functions for the school refusal behavior (Kearney, 2001). Results from teacher formal rating scales, teacher interview, and teacher observations should be evaluated for consistency with parent and child SRAS scores, and parent and child formal assessment scores. It is common for parent and teacher formal rating scales to indicate different concerns because children behave different in school than they do at home. In cases where averaged SRAS scores indicate multiple functions for school refusal behavior, the practitioner should consider which function has the most valence, and rely more on the student SRAS form, student interview, and the teacher interview and observations to guide treatment (Kearney, 2001; Kearney, 2003). The following sections offer evidence-based interventions for each type of school refusal behavior, a timeline for offering the intervention, and ready-made worksheets to assist with conserving practitioner time and energy. Interventions are an amalgam of research presented in previous chapters and are not referenced separately. All ready-made worksheets are free source material available online at psychologytools.com, www.search-institute.org (2011), and the Center for Clinical Intervention (2007) at www.cci.health.w.gov.au.

School Refusers Who Escape Negative Affect and/or Social or Evaluative Situations

New York University Child Study Center (Setzer & Salzhauer, 2001) offers the following case study for a student refusing school to escape negative affect:

Rebecca, an eight-year-old girl, has always had difficulty attending school. Since she began Third grade two months ago, her problems have significantly worsened. She constantly begs to stay home from school, having tantrums that cause delay in dressing and often result in her missing the bus. After arriving at school, Rebecca frequently complains of stomachaches, headaches and a sore throat to her teacher and asks to visit the school nurse with whom she pleads to call her mother. Her mother typically picks her up early twice a week. When Rebecca gets home she spends the remainder of the afternoon watching TV and playing with her toys. When her mother is unable to pick her up early, Rebecca calls her mother's cell phone periodically throughout the afternoon to "check in" and reassure herself that nothing bad has happened. Rebecca's teacher has expressed concern about her missing so much class time which has resulted in incomplete assignments and difficulty learning.

New York University Child Study Center (Setzer & Salzhauer, 2001) offers the following case study for a student refusing school to escape social or evaluative situations:

Nicholas is a fourteen-year-old boy who has missed forty-three days of school since the beginning the eighth grade four months ago. When home from school, Nicholas spends most of the day online or playing video games. On the days he does attend school he is typically late for his first period which enables him to avoid hanging out with other kids before class. He always goes to the library during lunch. When he does go to class, he sits in the back of the classroom, never raises his hand and has difficulty working on group projects. Nicholas' teachers have noticed that he is always absent on days that tests or book reports are scheduled. His parents have already punished him after his first report card came home since he received D's in Math and Social Studies and failed Gym for cutting. Nicholas' parents have started to wonder if they should change his school placement and have asked the school to arrange home tutoring while this alternative is explored.

Students who refuse school to escape from negative affect or avoid social or evaluative situations will likely score highest for those functional area of the SRAS form across both parent and child forms, however the high score might only be present in the child's form. Both of

these functions suggest internalizing problems or anxiety-related psychopathology. Negative affect will typically include feelings of anxiety, panic, depression, or fear. Social and evaluative situations will likely include taking tests, competing, or engaging in classroom or non-classroom social activities, both structured and unstructured, with peers. Often students who have difficulty with peer interactions do not have difficulty relating to adults. The following treatment map should be used for students who refuse school to escape from negative affect or avoid social and/or evaluative situations: psychoeducation around anxiety, depression, performance anxiety, and social anxiety (as needed depending upon the student), cognitive restructuring, creating an anxiety hierarchy, ABCs of behavior, relaxation training, and role play and/or imaginal exposure, and stepped desensitization and exposure exercises. In Addition, a goal attainment scale should be created by the service provider and the student in order to identify student success or worsening symptoms or behaviors. Please note that treatment weeks overlap. The manual was designed to encourage the service provider to move forward in treatment or hold back in treatment as is necessary to support student growth, mitigate negative symptoms, and encourage student self-efficacy.

Week Zero – Pre-Intervention:

Parents should meet with service provider and be apprised of the limits of confidentiality with regard to counseling and the suggested treatment plan. Provider should explain Behavior Observation Worksheet to parents (or guardian) and form should be completed prior to first week of intervention (see Appendix). Service provider should seek to establish rapport with the student for future meetings. Tacit assent should be sought from student and the limits of confidentiality should be discussed with the student. Written parental consent should be obtained.

Week One:

Provider should create a baseline (Level 0) for the Goal Attainment Scale and consider appropriate progress and regression for Level +/- 1 and 2. Level +2 should be associated with average absences for individuals in the school or district if such information is available. If this data is not available, then ten absences per year should be the limit, which translates to approximately one absence per month. Rapport should be established with student, however the provider should limit discussion in areas which will be anxiety provoking for the student and concentrate on rapport building. Provider should use this meeting to discuss personal stories which will ground later psychoeducation in real world experience and normalize the student's fear and anxiety indirectly. In addition, the provider should increase student awareness of personal, developmental assets to increase student's recognition that the presenting concern (school refusal) is not the sole defining characteristic for the student. The Search Institute 40 Developmental Assets website provides open source material for such a purpose (<http://www.search-institute.org/developmental-assets/lists>). The developmental asset lists are not printed in the appendix, however they are available online in various languages and adapted for specific age ranges to account for various developmental levels.

Week Two through Three:

Provider should provide psychoeducation around anxiety and negative affect in a way which is developmentally appropriate. Psychoeducational handouts are available for parents and adolescents, and older children, if they are able to understand the content of the handout (see appendix). Younger students should receive similar psychoeducation in a manner which is age appropriate and concrete to increase understanding. During this phase of intervention, students

will recognize that feelings, thoughts, and behaviors all affect each other. Students should begin to list some of the activities that provoke anxiety, negative affect, or negative self-evaluations. Students can begin to assign different levels of fear or anxiety to school based activities, including home activities associated with getting ready for school, on My Fear Thermometer or the Anger and Fear Thermometer, depending upon their age (see Appendix). The student should be instructed to write, or dictate if they are unable to write the information down themselves, which activities create the most fear for them. For example, leaving the house in the morning may cause them the greatest level of fear (Level 10), whereas getting up in the morning causes them a Level 5. For students with more significant anxiety around social or evaluative situations, a Level 10 fear might be offering an oral presentation on front of their class, whereas having lunch with fellow students might provoke a Level 5 fear, or vice versa. Students should create an anxiety hierarchy according to their most to least feared situations. As students identify their fears, the service provider should begin to explore physiological symptoms associated with fear using the Threat System, Chester the Cat Feels Anxious, and Anxiety in My Body handouts (see Appendix). Students should identify where they typically feel fear within their own body and chart that on the provided handout, paying special attention to which fears are felt in which areas more often. For example, a student imagining his anxiety related to giving an oral presentation might have the most significant physiological symptoms in his head (e.g. thoughts racing), then in his mouth (dry mouth), then in his heart (racing heartbeat). The goal is for the student to become familiar with the somatic sense of fear that arises from the various anxiety-provoking situations provided during the thermometer exercise. Weekly interventions will produce student homework in the areas covered during the weekly session and homework should be practiced daily at school or home, or both if possible.

Week Three through Six:

The practitioner will begin to train the student in progressive relaxation exercises. All students will benefit from learning to relax all of their muscles using a guided exercise. The robot-ragdoll method may be especially useful for younger children (e.g. tense up your arms like you are a robot for 15 seconds while counting, let your arm hang loose like you are a ragdoll for 15 seconds), whereas older children can be guided according to the practitioner's progressive relaxation exercise of choice or using the Progressive Muscle Relaxation Script (see Appendix). At this stage, students should begin pairing automatically distressing, or anxiety provoking, situations with cognitions, and with affect. In Addition, the student should identify the behavioral response that the anxiety-provoking thought causes. The Anxiety Symptoms Worksheet for younger children and older children can be used to record this data (see Appendix). This activity should be explored with students in depth. Students would benefit from the practitioner sharing some personal stories about him/herself and real or imagined stories of similarly aged students who demonstrate the cycle of anxiety producing situation --> creates somatic response --> creates distressing thoughts ---> increases emotions ---> produces (non-desirable) behaviors. When younger students demonstrate some understanding of the interdependence of these separate constructs (thoughts, emotions, somatic response, behavior), they should complete The STOP Plan (see Appendix), completing the form on their own or dictating to the practitioner, or drawing, depending upon the student's ability. The STOP Plan adds a new dimension to the anxiety cycle that offers alternative, helpful thoughts to replace the more maladaptive thought. Older students, or those that are developmentally able, should complete the Thought Diary (see Appendix) at home, or complete the diary during intervention sessions. The thought diary teases apart activating events, beliefs, consequences, and assists

students with identifying unhelpful thinking styles (which are illustrated in the Thinking Traps worksheet in the Appendix). The thought diary also identifies somatic responses, encourages disputation of the unhelpful thinking style, identifies the HOT thought (the HOT thought is the thought that provokes the most anxiety and/or greatest somatic response), and asks students to derive a new balance thought. The practitioner will find it useful to work with student's Core Beliefs (see worksheet in Appendix) and find experiences in the student's life that do not adhere to the unhelpful thinking style that supports maladaptive core beliefs. Providing the student with evidence that s/he already has the skill-set necessary for an alternative behavioral response increases student self-efficacy. The practitioner might begin role play practice for students with social anxiety and anxiety around evaluative situations. In Addition, the practitioner may begin imaginal exposure (pretending that a situation is occurring, envisioning it in one's mind) for students who are refusing school in order to escape negative affect. Progressive relaxation techniques should continue to be practiced at home and in session. Weekly interventions will produce student homework in the areas covered during the weekly session and homework should be practiced daily at school or home, or both if possible.

Week Six through Eight:

Students should continue to work on imaginal exposure and role playing in situations which are recognized as less anxiety provoking on their anxiety and fear hierarchy. The practitioner should take time to notice gains in student recognition and acknowledgement of anxiety-provoking situations and alternative behavioral responses. Praising student self-awareness will encourage the growth of self-efficacy. In Addition, as imaginal exposure and role playing is practiced during treatment sessions, the practitioner should assist students in identifying somatic responses and practicing relaxation techniques to decrease tension in that

part of the body. After some confidence has been built using imaginal exposure, students may begin to explore in-vivo exposure to the situations where anxiety is the least obtrusive and lower on the anxiety hierarchy chart (using the anxiety hierarchy established in previous sessions). Weekly interventions will produce student homework in the areas covered during the weekly session and homework should be practiced daily at school or home, or both if possible.

Week Eight through Twelve:

Students should begin to engage in in-vivo exposure beginning with the activity which provokes the least amount of anxiety. Parents need to be involved in this activity if the lowest anxiety-provoking level is associated with at-home behaviors or transitions. Parents need to be briefed with regard to positive parenting practices for anxious or depressed children; in either case, students are not positively reinforced with attention when they engage in excessive reassurance seeking. Much like parents, when practitioners are involved with in-vivo exposure, they must encourage students, identify and praise expected behaviors, and limit attending to excessive reassurance seeking from the student. Both parents, when the in-vivo exposure is occurring at home, and practitioners, when the in-vivo exposure is occurring at school or in the therapy office, should demonstrate an attitude of expectation that the student will manage the task, and should offer praise when the student is successfully tolerates an anxiety-provoking situation without engaging in undesirable behavior. Students will need to be seen more often during this phase of exposure so build upon successes. Once per week treatment will need to be increased to twice or more per week, however, scheduled times can be shorter for most sessions. Parents should be encouraged to respond to the student's success not only through praise, but through interest which can be demonstrated by asking questions which focus on the problem solving skills used by the student to successfully navigate an anxiety-provoking or

negative-affect provoking task. Parent-child dialogue which affirms negative affect (e.g. statements like “you must have been so scared”) is to be discouraged. In cases where students demonstrate the greatest anxiety around social or evaluative situations, in-vivo exposure is difficult to practice. For example, if a student’s highest level of anxiety is related to giving an oral report, such an opportunity may not present itself during the intervention period. The student and practitioner might engage in an artificial presentation in order to bridge the imaginal exposure to the in-vivo exposure. Using in-vivo exposure, the students will continue to work their way up through their anxiety hierarchy. Both parents and practitioners should be aware that success is slowly approximated, and each step toward alternative, desirable behavior is considered a success. During the last two weeks, the service provider should brief the student that treatment is coming to an end (if the student has made adequate progress). For the second to final session, the service provider and student should identify the final GAS score, administer and score equivalent formal assessments (or similar assessments if equivalent measures are not available) as were administered preceding intervention, and identify student successes in navigating activities on the anxiety hierarchy. Parents too need to be informed when treatment will end and encouraged to foster continued success using positive expectations, reduced reassurance, queries about problem solving, and consistent routines surrounding nighttime and morning routines.

Tier 3 Support:

Students who do not make adequate progress according to the GAS, and according to formal assessments and interviews, should continue to receive treatment for two to four additional weeks. These weeks will primarily focus on in-vivo exposure and imaginal exposure depending upon student tolerance for the exposure. Students should receive additional training

regarding problem-solving techniques (see appendix). In Addition, as student intolerance manifests, the practitioner should assist students with relaxation techniques paired with exposure. Weekly interventions will produce student homework in the areas covered during the session and homework should be practiced daily at school or home, or both if possible.

Post-Intervention Boosters:

The students should be seen monthly for a single visit for several months after treatment in order to discuss continued success and practice relaxation exercises paired with imaginal exposure for more difficult anxiety-provoking situations. In Addition, students who have “graduated” the intervention may be asked to act as peer mentors or special guests for current intervention groups. This may be satisfying for both graduates and intervention students. In Addition, the booster sessions may provide students who demonstrate social anxiety with an opportunity to practice speaking in front of (less threatening) students.

**School Refusers who Seek Attention or
Positive Tangible Reinforcement Outside of School**

School Refusal to Seek Attention Case Study:

Christina is a twelve year old girl, just starting her first year in middle school. She has missed 10 days of school within the last month. She tells her mother that she does not feel well in the morning and is unable to attend school. Her mother urges her to go to school, however Christina insists that she is not feeling well. Her mother is a homemaker and does not work outside of the home. When Christina stays at home, she helps her mother clean house and cook lunch and dinner. She watches her mother's favorite television programs with her as well. Christina denies any peer-problems at school and often plays with friends after school on days where she is absent and on days when she attends school.

School Refusal to Seek Positive Tangible Reinforcement Outside of School Case Study:

Brian is a 15 year old boy, in 10th grade at a public high school. He typically misses the equivalent of one to two school days per week when missed classes are coupled with missed full-days. Sometimes he leaves for school before his mother and father leave for work, but parents often get a "robo-call" from the school informing them that Brian was absent for one or more periods. When confronted, Brian often makes excuses that he didn't feel well, or that he completed his work and wanted to go home. Brian confirms that when he is not in school that he often rides his bike around the neighborhood, plays basketball in the park, or plays videogames at home. His parents have been unable to enforce rules around school attendance. Brian has had issues with oppositional behavior at home since he was a child.

Students who refuse school to seek attention will likely score highest for that functional area of the SRAS form across both parent and child forms, however the high score might only be present in the parents form. Whereas students who refuse school to seek tangible rewards outside of school will likely score highest for that functional area of the SRAS form across both parent and child forms, however the high score might only be present in the student form if parents are unaware of their child's behavior when s/he is absent from school. The following treatment map should be used for students who refuse school to for parental attention or to seek tangible rewards outside of school: parent contingency training, parent assertiveness training, establishing routines, and use of rewards and punishments for targeted behaviors. In Addition, a goal attainment scale should be created by the service provider and the student in order to identify student success or worsening symptoms or behaviors.

Week Zero – Pre-Intervention:

Parents should meet with service provider and be apprised of the limits of confidentiality with regard to counseling and the suggested treatment plan for the student. The suggested treatment plan for students who refuse school to seek attention or tangible rewards outside of school will consist of parent training, problem solving, contingency management, and student contracting with school and parents. In Addition, the student will be seen weekly to discuss progress and create self-directed goals relative to school. Parents will be asked to attend weekly group sessions for one hour. If the service provider offers parent group training, then sessions will likely need to be longer (two hours) to accommodate for more parent questions. In Addition, if schools have existing parent training interventions, the suggested treatment plan focus (school refusal) can be integrated into the existing intervention, and weekly modules can be modified to

include components from the present suggested treatment plan (below).

Week One:

Provider should create a baseline (Level 0) for the Goal Attainment Scale and consider appropriate progress and regression for Level +/- 1 and 2. Level +2 should be associated with average absences for individuals in the school or district if such information is available. Rapport should be established with parents and an overview of parent training will be introduced. Students should not be present for parent training sessions, instead, service provider should meet with student separately to discuss some changes which s/he can expect to see in his/her household and to develop rapport. The limits of confidentiality should be addressed with each student. In Addition, the service provider should explore positive influences at school with non-delinquent peers, teachers, and other school staff because positive in-school relationships may help the student to abide by the behavior contracts which will be established over the next sessions. Practitioners can obtain a list of internal and external assets from The Search Institute (2011) from <http://www.search-institute.org/developmental-assets/lists> in order to explore to explore assets with the student.

Week Two through Four:

Parents will be provided with basic psychoeducation regarding parent command training, establishing fixed routines, identifying child behaviors to focus upon, contingency contracting (rewarding appropriate predefined behavior and punishing inappropriate predefined behavior), and behavioral contracting.

First, parents should identify the current household morning routine, after school routine,

and evening routine. Service providers should be flexible and sensitive to parent needs when making value judgments about appropriate versus inappropriate household routines. For example, some parents stodgily stick to a schedule which requires children to do homework immediately after school, whereas other parents allow for down time after school and begin homework after dinnertime. Neither of the schedules is right or wrong, instead the schedule is either effective or ineffective in producing the desired results. Relative to this treatment manual, family schedules should be examined to discover whether they encourage or discourage school refusal behavior.

With the assistance of the service provider, parents should use the problem solving model (see appendix for iconic representation of steps) to choose which student behaviors, relative to school refusal, are the most problematic. Parents should choose four to five target behaviors total, focusing on only one or two behaviors at a time. Choosing too many behaviors, and focusing on all of them at once, reduces the chances that the student will succeed with expected behavior changes. When too many behaviors are targeted, parents are unable to monitor all targeted behaviors, and are unable to respond appropriately with reinforcement or punishment to targeted behaviors. In Addition, especially within the first weeks of parent training, non-targeted behaviors should be ignored during implementation of the contingency management program, unless the behavior is dangerous to the student or to others. Students should be informed of the target behaviors identified during the problem solving process in a matter of fact manner which demonstrates the parental expectation that the student is capable of success (see Behavior Contract in Appendix).

Parents should be given parent command training to streamline their communication with their child in order to reduce conflict and increase compliance. Parent command training has

been adapted from the Parents in Control program, which is used within the Los Angeles Unified School District for parent training. Parent commands should be direct, stated in an expecting, non-frustrated tone. Commands are not posed as a question, not vague, and have an specific end-point (e.g. in five minutes) in which the request will be complied with. Also, commands should be one or two steps (not more), and devoid of criticism, sarcasm, or lecturing. With regard to the verbal content of parental command training, parents should engage in role-play under the direction of the service provider to prepare for expected difficulties with this new form of communication during each session. In Addition, parents should practice giving praise to the child to increase compliance and improve the parent-child relationship. Parental commands should be uttered when the parent is proximally close to the child, as opposed to commands shouted from a different room, and parents should remain close to the child until the task is completed. Typically, for behaviorally challenged students, if the child is not watched, the task will likely not be completed. Remind parents that the only tasks which require this focused attention and intent are those have been previously identified as the current targeted behavior. When the child complies with the task, they should be rewarded with attention and praise immediately. This is especially important when the identified function of the school refusal behavior is attention seeking, but important for students who are seeking tangible rewards as well.

For students who are seeking tangible rewards outside of school, they should receive an agreed upon tangible reward for the targeted behaviors after a predetermined quantity of a targeted behavior is observed. The predetermined amount needs to be variable as it will be dependent upon the child's developmental age and child's tolerance for the frustration which often accompanies waiting. In this case, more frequent, smaller rewards may be appropriate.

The parent should have some idea as to what the child can and cannot tolerate and what rewards will be most motivating for the child. In Addition, the child will be aware that they are working toward a reward (see Rewards Chart in Appendix). Also, only one or two behaviors should be focused on at a time. Other simple, inappropriate behaviors should be ignored; this is especially for attention-seeking children.

Students should meet weekly with the service provider to discuss personal successes related to the behavioral contract, and the current targeted behaviors. In Addition, in-school problems should be discussed weekly with the student, and the problem solving model (see appendix) should be directly taught to the student. After practicing the problem solving model with the service provider several times, the student should be directed to use the model on his own. As much as possible, the problem solving model should be directed by the student to increase self-efficacy, with only enough limited support offered by the service provider. In addition to recognizing improvement in targeted behaviors, increased attendance should be recognized and celebrated by the student, the service provider, and any in-school supports identified during the first week (e.g. a teacher, teacher's aide, administrator, etc.).

Week Five through Eight:

The child will have probably shown improvement in one or both of the targeted behaviors at this time. If one behavior is consistently demonstrated, the reinforcement should be slowly extinguished and replaced with a new (previously established) targeted behavior. The same routine as in Weeks Two through Four should continue with the new behavior/s. In session with the service provider, parents should continue to practice parental commands and offering praise by engaging in role-play. It's important to remind parents that offering praise and

recognition will improve the parent-child relationship. In Addition, parents should begin to identify which behaviors are contributing to increased or decreased school refusal behavior with regard to the household schedule. As these are clarified with the parent/s and the service provider, a rough draft should be developed for what is expected in the morning before school, and in the afternoon immediately afterschool, as well as in the evening, bedtime routine. That schedule should be posted for the family to visually reinforce expectations, and ideally older children should be part of establishing the schedule to increase student buy-in (i.e. compliance) for the revised household routine.

Students should sign the new behavior contract (with newly targeted behaviors) as well as work with parents to identify rewards for new behaviors. If the child demonstrates increased compliance to the new schedule (non-targeted behaviors) in addition to the targeted behaviors, the student should be praised for any new behaviors which approximate more desirable behaviors. This is referred to as behavioral shaping. In Addition, at week seven through eight, the child should be encouraged by parents (and service provider) to monitor him/herself relative to non-targeted behaviors. At week eight, the GAS should be revisited to check on student progress.

Tier 3 Support:

Students who do not make adequate progress according to GAS and according to formal assessments completed by parents and students should continue to receive treatment for two to four weeks continuing with training in problem-solving skills, but this time the treatment should include parents and students in session together, not separately. Parents should encourage the student to self-monitor progress toward targeted behaviors and praise the increased self-efficacy

that is required for self-monitoring. Parents should continue to work on extinction of reinforcement for targeted behaviors that are regularly performed and agreeing on new targeted behaviors, preferably with child agreement. In Addition, parents should continue to practice verbalizing commands as learned during parent command training. The service provider should act as a facilitator for turning over responsibility to the family.

Mixed Type School Refusers

Most school refusers will demonstrate mixed functionality and varied etiology relative to school refusal behavior. As previously mentioned in earlier chapters, the primary reason for school refusal should be what guides treatment. If the student demonstrates nearly equivalent scores on the SRAS for internalizing behaviors (those driven by escape from social or evaluative situations, and those driven by avoidance of negative affect) and externalizing behaviors (those driven by attention seeking or desire to pursue tangible rewards outside of school), the service provider is encouraged to pursue both arms of treatment depending upon available time and resources. If this option is not available, as would be expected given the limited resources available in schools at this time, the practitioner is encouraged to determine the best treatment protocol for each individual student. If the provider determines to offer treatment based upon internalizing symptoms, parents can be offered materials made available in the Appendix of this manual for use at home, and to use the provider as a consultant in developing home-based interventions to support increased student attendance.

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Appendix

School Refusal Assessment Scale-Revised (Child)

Children sometimes have different reasons for not going to school. Some children feel badly at school, some have trouble with other people, some just want to be with their family, and others like to do things more fun outside of school.

This form asks questions about why you don't want to go to school. For each question, pick one number that describes you best for the last few days. After you answer one question, go on to the next. Don't skip any questions.

There are no right or wrong answers. Just pick the number that best fits the way you feel about going to school. Circle the number.

Here is an example of how it works. Try it. Circle the number that describes you best.

Example:

How often do you like to go shopping?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

Now go to the next page and begin to answer the questions.

DO NOT COPY

School Refusal Assessment Scale-Revised (Child Form)

Name: _____

Age: _____

Date: _____

Please circle the answer that best fits the following questions:

1. How often do you have bad feelings about going to school because you are afraid of something related to school (for example, tests, school bus, teacher, fire alarm)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

2. How often do you stay away from school because it is hard to speak with the other kids at school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

3. How often do you feel you would rather be with your parents than go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

4. When you are not in school during the week (Monday to Friday), how often do you leave the house and do something fun?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

5. How often do you stay away from school because you will feel sad or depressed if you go?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

DO NOT COPY

6. How often do you stay away from school because you feel embarrassed in front of other people at school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

7. How often do you think about your parents or family when in school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

8. When you are not in school during the week (Monday to Friday), how often do you talk to or see other people (other than your family)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

9. How often do you feel worse at school (for example, scared, nervous, or sad) compared to how you feel at home with friends?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

10. How often do you stay away from school because you do not have many friends there?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

11. How much would you rather be with your family than go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

12. When you are not in school during the week (Monday to Friday), how much do you enjoy doing different things (for example, being with friends, going places)?

+

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

□

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13. How often do you have bad feelings about school (for example, scared, nervous, or sad) when you think about school on Saturday and Sunday?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

14. How often do you stay away from certain places in school (e.g., hallways, places where certain groups of people are) where you would have to talk to someone?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

15. How much would you rather be taught by your parents at home than by your teacher at school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

16. How often do you refuse to go to school because you want to have fun outside of school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

17. If you had less bad feelings (for example, scared, nervous, sad) about school, would it be easier for you to go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

18. If it were easier for you to make new friends, would it be easier for you to go to school?

+				Half the		Almost	
	Never	Seldom	Sometimes	Time	Usually	Always	Always
	0	1	2	3	4	5	6

DO NOT COPY

19. Would it be easier for you to go to school if your parents went with you?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

20. Would it be easier for you to go to school if you could do more things you like to do after school hours (for example, being with friends)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

21. How much more do you have bad feelings about school (for example, scared, nervous, or sad) compared to other kids your age?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

22. How often do you stay away from people at school compared to other kids your age?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

23. Would you like to be home with your parents more than other kids your age would?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

24. Would you rather be doing fun things outside of school more than most kids your age?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

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	Do not write below this line			
1.	2.	3.	4.	
5.	6.	7.	8.	
9.	10.	11.	12.	
13.	14.	15.	16.	
17.	18.	19.	20.	
21.	22.	23.	24.	

Total				
Score =				
Mean				
Score =				
Relative				
Ranking				
=				

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School Refusal Assessment Scale- Revised (Parent)

Name: _____

Date: _____

Please circle the answer that best fits the following questions:

1. How often does your child have bad feelings about going to school because he/she is afraid of something related to school (for example, tests, school bus, teacher, fire alarm)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

2. How often does your child stay away from school because it is hard for him/her to speak with the other kids at school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

3. How often does your child feel he/she would rather be with you or your spouse than go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

4. When your child is not in school during the week (Monday to Friday), how often does he/she leave the house and do something fun?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

5. How often does your child stay away from school because he/she will feel sad or depressed if he/she goes?

⊕

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

□

DO NOT COPY

6. How often does your child stay away from school because he/she feels embarrassed in front of other people at school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

7. How often does your child think about you or your spouse or family when in school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

8. When your child is not in school during the week (Monday to Friday), how often does he/she talk to or see other people (other than his/her family)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

9. How often does your child feel worse at school (for example, scared, nervous, or sad) compared to how he/she feels at home with friends?

⊕

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

10. How often does your child stay away from school because he/she does not have many friends there?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

11. How much would your child rather be with his/her family than go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

DO NOT COPY

12. When your child is not in school during the week (Monday to Friday), how much does he/she enjoy doing different things (for example, being with friends, going places)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

13. How often does your child have bad feelings about school (for example, scared, nervous, or sad) when he/she thinks about school on Saturday and Sunday?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

14. How often does your child stay away from certain places in school (e.g., hallways, places where certain groups of people are) where he/ she would have to talk to someone?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

15. How much would your child rather be taught by you or your spouse at home than by his/her teacher at school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

16. How often does your child refuse to go to school because he/she wants to have fun outside of school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

DO NOT COPY

17. If your child had less bad feelings (for example, scared, nervous, sad) about school, would it be easier for him/her to go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

18. If it were easier for your child to make new friends, would it be easier for him/her to go to school?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

19. Would it be easier for your child to go to school if you or your spouse went with him/her?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

20. Would it be easier for your child to go to school if he/she could do more things he/she likes to do after school hours (for example, being with friends)?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

21. How much more does your child have bad feelings about school (for example, scared, nervous, or sad) compared to other kids his/ her age?

⊠

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

□

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22. How often does your child stay away from people at school compared to other kids his/her age?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

23. Would your child like to be home with you or your spouse more than other kids his/her age would?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6

24. Would your child rather be doing fun things outside of school more than most kids his/her age?

			Half the		Almost	
Never	Seldom	Sometimes	Time	Usually	Always	Always
0	1	2	3	4	5	6
Do not write below this line						
1.		2.	3.	4.		
5.		6.	7.	8.		
9.		10.	11.	12.		
13.		14.	15.	16.		
17.		18.	19.	20.		
21.		22.	23.	24.		

Total Score =				
Mean Score =				
Relative Ranking =				

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INSTRUCTIONS FOR SCORING THE SRAS-R

Following completion of each questionnaire, derive item means for each function. On the SRAS-R-C and each SRAS-R-P, therefore, scores are added for:

- Items 1, 5, 9, 13, 17, and 21 (first function).
- Items 2, 6, 10, 14, 18, and 22 (second function).
- Items 3, 7, 11, 15, 19, and 23 (third function).
- Items 4, 8, 12, 16, 20, and 24 (fourth function).

These four total scores are then each divided by six (or number of items answered in each set). For example, if a child's total rating score across the:

- First item set was 18, then the item mean would be 3.00.
- Second item set was 12, then the item mean would be 2.00.
- Third item set was 36, then the item mean would be 6.00.
- Fourth item set was 6, then the item mean would be 1.00.

Do this separately for ratings from the child, mother, and father.

After this is done, compute the mean item scores per functional condition across all SRAS-R versions given. Assume, for example, that the:

- Child's mean item scores from the SRAS-C were: 3.00, 3.50, 6.00, and 0.50.
- Mother's mean item scores from the SRAS-P were: 4.00, 4.50, 5.50, and 1.00.
- Father's mean item scores from the SRAS-P were: 3.50, 4.50, 5.00, and 1.50.

In this case, therefore, the:

- Overall mean for the first function would be: 3.50 $(3.00 + 4.00 + 3.50/3)$.
- Overall mean for the second function would be: 4.17 $(3.50 + 4.50 + 4.50/3)$.
- Overall mean for the third function would be: 5.50 $(6.00 + 5.50 + 5.00/3)$.
- Overall mean for the fourth function would be: 1.00 $(0.50 + 1.00 + 1.50/3)$.

The highest scoring function is considered to be the primary reason why a particular child is refusing school. Scores within 0.25 points of one another are considered equivalent (in one treatment study, scores within 0.50 points of one another were also considered equivalent). In this case, therefore, the highest scoring function is the third one, or attention-seeking (5.50). However, these numbers also provide a profile of related influences. In this case, for example, the child may be somewhat refusing school for the first and second functions (i.e., avoidance of stimuli provoking negative affectivity and escape from aversive social and/or evaluative situations; 3.50 and 4.17). However, the relative influence of the fourth functional condition, tangible rewards, is low (1.00) and may not be a substantial factor. Remember that these are hypotheses based on child and parent ratings.

Figure 2-3
Behavioral Observation For School Refusal Behavior

CHILD'S NAME: _____

DATE: _____

Needed: Stopwatch, daily logbook forms

Instructions for the recorder or the parent if a recorder is not available
(FOLLOW THESE INSTRUCTIONS STEP BY STEP):

Prior to the home visit, discuss the 0-10 rating scale with the child and parents. Describe in detail the constructs of negative affectivity (i.e., general negative mood including anxiety and depression) and noncompliance (i.e., refusal to comply with parental commands/requests). Distribute to each party a copy of the daily logbook form for review.

Schedule a time to meet with the family in their home setting on a school day. Determine the child's rising time (e.g., 6:30 a.m.) and schedule to arrive 15 minutes earlier. Using a stopwatch, record the amount of time the child resists activities that serve to prepare her for school attendance.

Specifically, record time in minutes taken for the following:

(1) Verbal/physical resistance to rise from bed at the pre-specified time. Verbal/physical resistance in this situation is defined as any verbalization, vocalization, or physical behavior that contradicts school attendance. In this situation, such behaviors might include (but are not limited to) verbal and physical noncompliance, clinging to bed, locking oneself in a bedroom, or refusal to move.

(2) Verbal/physical resistance to dressing, washing, and eating. Verbal/physical resistance in this situation is defined as any verbalization, vocalization, or physical behavior that contradicts school attendance. In this situation, such behaviors might include (but are not limited to) verbal and physical noncompliance, clinging, screaming, crying, throwing objects, aggressive behavior, locking oneself in a room, running away, or refusal to move.

(3) Verbal/physical resistance to riding in a car/bus to school.

Verbal/physical resistance in this situation is defined as any verbalization, vocalization, or physical behavior that contradicts school attendance. In this situation, such behaviors might include (but are not limited to) verbal and physical noncompliance, locking oneself in the car, screaming, crying, aggressive behavior, running away, or refusal to move.

(4) Verbal/physical resistance to entering the school building.

Verbal/physical resistance in this situation is defined as any verbalization, vocalization, or physical behavior that contradicts school attendance. In this situation, such behaviors might include (but are not limited to) verbal and physical noncompliance, clinging, screaming, crying, aggressive behavior, running away, or refusal to move.

In addition, record the child's rating of negative affectivity on the 0–10 scale where 0 = none, 2 = mild, 4 = moderate, 6 = marked, 8 = severe, and 10 = extreme. Use any number 0–10. REMIND THE CHILD TO USE THE ENTIRE RANGE OF RATINGS.

Record this rating twice:

- (1) In the middle of morning preparation activities.
- (2) Upon entering the school building (if applicable).

In addition, record the parent's rating of child negative affectivity and noncompliance on the 0-10 scale where 0 = none, 2 = mild, 4 = moderate, 6 = marked, 8 = severe, and 10 = extreme. Use any number 0-10. REMIND THE PARENT TO USE THE ENTIRE RANGE OF RATINGS.

Record this rating twice:

- (1) In the middle of morning preparation activities.
- (2) Upon entering the school building (if applicable).

Contact the school attendance officer at the child's school to record any time missed that school day. Complete all remaining sections of the recording sheet for the behavioral approach test.

Recording Sheet for Behavioral Observation

PARTICIPANTS: _____

DATE/TIME: _____

1. Record total verbal/physical resistance time for rising from bed:

TOTAL MINUTES: _____

2. Record total verbal/physical resistance time for dressing, washing, and eating:

TOTAL MINUTES: _____

3. Record child rating (0–10) of negative affectivity at midpoint of morning preparation activities:

RATING: _____

4. Record parent rating (0–10) of child's (a) negative affectivity and (b) noncompliance at midpoint of morning preparation activities:

NEGATIVE AFFECTIVITY RATING: _____

NONCOMPLIANCE RATING: _____

5. Record total verbal/physical resistance time for riding in a car or bus to school:

TOTAL MINUTES: _____

6. Record total verbal/physical resistance time for entering the school building:

TOTAL MINUTES: _____

7. Record child rating (0–10) of negative affectivity upon entering school building (if applicable):

RATING: _____

8. Record parent rating (0–10) of child's (a) negative affectivity and (b) noncompliance upon entering school building (if applicable):

NEGATIVE AFFECTIVITY RATING: _____

NONCOMPLIANCE RATING: _____

9. Record total amount of time missed during the school day:

TOTAL MINUTES: _____

10. Record total amount of resistance time plus time missed during the school day:

TOTAL MINUTES: _____

11. Record total time between rising time and end of school day:

TOTAL MINUTES: _____

12. Calculate percentage of resistance/missed time to total time between rising time and end of school day:

PERCENTAGE: _____

Behavioral Observation Worksheet

Monday Tuesday Wednesday Thursday Friday

Refuses/cannot get out of bed
Refuses to move
Will not get ready for school
Locks self in room or car
Cries a lot
Temper tantrum
Excessive dawdling
Clings to an adult
Stomachache or other complaint
Runs away from home or school

what is depression?

Many people experiencing the symptoms of depression might begin to wonder if there is something really wrong with them. One typical fear is that they might be going crazy. Unfortunately, the reactions and comments from other people such as, "Just get yourself together!" are not very helpful.

Although you might feel alone in your struggle against depressive moods, the reality is that many people experience these moods from time to time, or even regularly. In fact, it is estimated that 1 in every 4 people experience significantly depressed mood at some time in their life.

Depression can affect any kind of person at any stage of their life. You may be an introvert or an extrovert, socially active or shy, youthful or elderly, male or female, wealthy or poor. Whatever your distinction, you can become depressed. That means that any person you know is fair game. So remember, you are not alone.

Depression is a word used in everyday language to describe a number of feelings, including sadness, frustration, disappointment and sometimes lethargy. However, in clinical practice, the term "Depression" or "Major Depression" differs from these everyday 'down' periods in three main ways:



- Major Depression is more intense
- Major Depression lasts longer (two weeks or more)
- Major Depression significantly interferes with effective day-to-day functioning

In this handout, the word **depression** is referring to Major Depression or a clinical depression.

Depression as a Syndrome

A syndrome is a collection of events, behaviours, or feelings that often go together. The depression syndrome is a collection of feelings and behaviours that have been found to characterise depressed people as a group. You may find that you experience all or some of these feelings and behaviours. There are many individual differences to the number of symptoms and the extent to which different symptoms are experienced. These symptoms are described in this next section.

Mood

Depression is considered to be a disorder of mood. Individuals who are depressed, describe low mood that has persisted for longer than two weeks. In mild forms of depression, individuals may not feel bad all day but still

describe a dismal outlook and a sense of gloom. Their mood may lift with a positive experience, but fall again with even a minor disappointment. In severe depression, a low mood could persist throughout the day, failing to lift even when pleasant things occur. The low mood may fluctuate during the day – it may be worse in the morning and relatively better in the afternoon. This is called 'diurnal variation,' which often accompanies a more severe type of depression.



In addition to sadness, another mood common to depression is anxiety.

Thinking

Individuals who are depressed think in certain ways, and this thinking is an essential feature of depression. It is as much a key symptom of depression as mood or physical symptoms. Those who are depressed tend to see themselves in a negative light. They dwell on how bad they feel, how the world is full of difficulties, how hopeless the future seems and how things might never get better. People who are depressed often have a sense of guilt, blaming themselves for everything, including the fact they think negatively. Often their self-esteem and self-confidence become very low.

Physical

Some people experience physical symptoms of depression.

- Sleep patterns could change. Some people have difficulty falling asleep, or have interrupted sleep, others sleep more and have difficulty staying awake
- Appetite may decline and weight loss occurs, while others eat more than usual and thus gain weight
- Sexual interest may decline
- Energy levels may fall, as does motivation to carry out everyday activities. Depressed individuals may stop doing the things they used to enjoy because they feel unmotivated or lethargic

Interacting with Other People

Many depressed people express concern about their personal relationships. They may become unhappy and dissatisfied with their family, and other close, relationships. They may feel shy and anxious when they are with other people, especially in a group. They may feel lonely and isolated, yet at the same time, are unwilling or unable to reach out to others, even when they have the opportunities for doing so.

what is **social anxiety?**

Almost everyone gets a little anxious or embarrassed in front of other people now and then, though some of us are more shy than others. Sometimes, though, the anxiety can be so intense that it stops us from doing the things we enjoy, or starts interfering in our daily lives. If this sounds familiar to you, this information sheet can help to give you a better idea of what *social anxiety* is.

Social anxiety is used to describe feelings of anxiety and fear that occur in response to social situations. Even the most confident of people can get a little anxious before a presentation, or when they're meeting new people, but in social anxiety this distress can be so overwhelming that it feels as though it's difficult to cope. Often, that overwhelming anxiety is experienced when just thinking about the situation or remembering a previous event. You may also have heard the term "social phobia" used to describe these feelings.

Perhaps you feel highly anxious and distressed only in some specific situations, such as presenting to a group of people, or perhaps you feel this anxiety across most situations that generally involve other people. Do you feel extremely anxious in any of the following situations?

- Being the center of attention
- Meeting new people
- Talking to people in authority
- Presentations or talking in front of people
- Parties and social gatherings
- Being watched while doing something, such as signing your name, eating, or drinking

These situations commonly cause distress for people with social anxiety, though there are certainly others. Whatever situation you might feel anxious in, there are a number of symptoms that you may feel in response to social situations.

Thoughts

Do you worry a lot about what other people think, or worry that you will do something embarrassing in front of others? Perhaps you really want other people to like you, or you want to do the right thing by others, and become really worried that you'll "mess it up". You might focus on other people's reactions, wondering how you look or what they are thinking about you. People with social anxiety are often very concerned that other people will think negatively of them and are especially worried about situations where they may be evaluated, criticised or embarrassed.

Physical

When you are in particular social situations, or thinking about social situations, you may experience a number of physical reactions. Perhaps you are sitting at work one day and your boss asks you to sit in on a meeting with some new clients. Your anxiety increases and all of a sudden, you become flustered; you start to feel warm, your breathing becomes irregular, your heart beats faster, you feel a little lightheaded and you have to close your eyes to try and settle yourself down. You may recognise some of these symptoms in relation to your own response to social situations.

- Heart palpitations, or racing and pounding heart
- Sweating
- Trembling or shaking
- Shortness of breath or a choking feeling
- Chest pain or a tightness in your chest
- Nausea
- Lightheadedness, dizziness, or feeling faint
- Chills or hot flushes
- Numbness or tingling sensations
- Blushing
- Dry throat and mouth

Avoidance

You may have been in a few social situations where you've wanted to hide away from everyone. As a result, you may have avoided these types of situations for some time – trying to escape from as many as you can, and feeling intense distress during the situations you can't avoid.



If you can relate to these symptoms, then social anxiety might be a problem in your life. Talk to your doctor or mental health professional about the kinds of symptoms that you get in social situations, and let them talk to you about what you can do to ease your anxiety.

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what is panic?



To understand panic, we need to understand fear. You can think of fear as an automatic alarm response that switches on the moment there is danger. Think about what would happen to you if a dangerous animal approached you. For most people it would be panic stations! You, and almost everyone, would go through a whole series of bodily changes, like your heart pumping, breathing faster, sweating, all in order to respond to the danger in front of you. This alarm response would probably lead us to either run for our lives or become sufficiently 'pumped up' to physically defend ourselves. This alarm response is an important survival mechanism called the fight or flight response.

Sometimes, however, it is possible to have this intense fear response when there is no danger – it is a false alarm that seems to happen when you least expect it. It is like someone ringing the fire alarm when there is no fire! Essentially, a panic attack is a false alarm.



Many people experience some mild sensations when they feel anxious about something, but a panic attack is much more intense than usual. A panic attack is usually described as a sudden escalating surge of extreme fear. Some people portray the experience of panic as 'sheer terror'. Let's have a look at some of the symptoms of a panic attack:

Panic Attack Symptoms

- Skipping, racing or pounding heart
- Sweating
- Trembling or shaking
- Shortness of breath or difficulty breathing
- Choking sensations
- Chest pain, pressure or discomfort
- Nausea, stomach problems or sudden diarrhoea
- Dizziness, lightheadedness, feeling faint
- Tingling or numbness in parts of your body
- Hot flushes or chills
- Feeling things around you are strange, unreal, detached, unfamiliar, or feeling detached from body
- Thoughts of losing control or going crazy
- Fear of dying

As you can see from the list, many of the symptoms are similar to what you might experience if you were in a truly dangerous situation. A panic attack can be very frightening and you may feel a strong desire to escape the situation. Many of the symptoms may appear to indicate some medical condition and some people seek emergency assistance.

Characteristics of a Panic Attack

- It peaks quickly - between 1 to 10 minutes
- The apex of the panic attack lasts for approximately to 10 minutes (unless constantly rekindled)
- The initial attack is usually described as "coming out the blue" and not consistently associated with a specific situation, although with time panics can become associated with specific situations
- The attack is not linked to marked physical exertion
- The attacks are recurrent over time
- During an attack the person experiences a strong urge to escape to safety

Many people believe that they may faint whilst having a panic attack. This is highly unlikely because the physiological system producing a panic attack is the opposite of the one that produces fainting.

Sometimes people have panic attacks that occur during the night when they are sleeping. They wake from sleep in a state of panic. These can be very frightening because they occur without an obvious trigger.

Panic attacks in, and of themselves, are not a psychiatric condition. However, panic attacks constitute the key ingredient of Panic Disorder if the person experiences least 4 symptoms of the list previously described, the attacks peak within about 10 minutes and the person has a persistent fear of having another attack.

Panic Disorder and Agoraphobia

Someone with panic disorder has a persistent fear of having another attack or worries about the consequences of the attack. Many people change their behaviour to try to prevent panic attacks. Some people are affected so much that they try to avoid any place where it might be difficult to get help or to escape from. When this avoidance is severe it is called Agoraphobia.



Panic Disorder is more common than you think. A recent study reported that 22.7% of people have reported experience with panic attacks in their lifetime 3.7% have experienced Panic Disorder and 1.1% have experienced Panic Disorder plus Agoraphobia. * These numbers equate to millions of people world wide. If left untreated, Panic Disorder may become accompanied by depression, other anxiety disorders, dependence on alcohol or drugs and may also lead to significant social and occupational impairment.

* Archives of General Psychiatry, 2006; 63:415-424



What is Perfectionism?



Perfectionism Defined

Perfectionism is not necessarily about being 'perfect'. Ask yourself this question... Is it ever really possible to be 100% 'perfect'? So, if it's not about being 'perfect', then what do we mean when talk about perfectionism?

Although there's no perfect definition, we understand perfectionism to involve:

1. The relentless striving for extremely high standards (for yourself and/or others) that are **personally** demanding, in the context of the individual. (Typically, to an outsider the standards are considered to be unreasonable given the circumstances.)
2. Judging your self-worth based largely on your ability to strive for and achieve such unrelenting standards.
3. Experiencing negative consequences of setting such demanding standards, yet continuing to go for them despite the huge cost to you.



The Paradox of Perfectionism

Many people think of perfectionism as something positive. It is often seen as the pursuit of excellence, setting high standards, and working hard to challenge one's self. People often have good reasons for being perfectionists. They may say that it allows them to be efficient, organised, or prepared for anything.

Although having high standards and goals may help us achieve things in life, sometimes these standards get in the way of our happiness and can actually *impair* performance. This is the **paradox of perfectionism!**

The excessive drive to achieve ever-higher levels of performance is self-defeating as it leaves you little chance of meeting your goals and feeling good about yourself. This kind of pressure is likely to cause you to feel constantly on edge, tense, and stressed out.

Perfectionism can also make your self worth particularly vulnerable as not reaching the (possibly unachievable) standards you set for yourself may result in you feeling like a failure.

Pursuing these personally demanding standards can have a significant impact on your wellbeing, and can lead to frustration, worry, social isolation, depression and a persistent sense of failure.

When am I a Perfectionist?

Being a perfectionist doesn't necessarily mean you have unrelenting high standards in every area of your life. It is possible to be a perfectionist in one area of your life (e.g., work), but not another (e.g., grooming).

Areas of life in which your perfectionism may flare up include:

- ◊ Work,
- ◊ Study,
- ◊ Housework/cleaning,
- ◊ Close relationships,
- ◊ Eating/weight/shape,
- ◊ Grooming/personal hygiene,
- ◊ Sport,
- ◊ Health & fitness.



How am I a perfectionist?

Some common types of perfectionistic behaviours include:

- ◊ Struggling to make decisions in a timely manner (e.g., not being able to decide what to wear to work each morning).
- ◊ Reassurance seeking. (E.g., asking others to check your work to ensure it is acceptable).
- ◊ Excessive organising and list making. (E.g., repeatedly writing and re-writing lists of the tasks you want to get done in the day).
- ◊ Giving up easily. (E.g., giving up flamenco after two lessons because you can't keep up with the teacher (even though nobody can)).
- ◊ Procrastinating. (E.g., putting off starting an assignment for fear that it won't be good enough).
- ◊ Not knowing when to stop. (E.g., arguing a point over and over, long after others have lost interest).
- ◊ Checking. (E.g., repeatedly looking in the mirror for facial blemishes).
- ◊ Hoarding. (E.g., keeping your bank statements for 20 years just in case you might need them).
- ◊ Slowness. (E.g., speaking slowly to ensure you say the right thing).
- ◊ Avoiding situations in which you may 'fail'. (E.g., not applying for jobs for fear that you will not get them).



For more detailed information regarding What is Perfectionism, see Perfectionism in Perspective Module 1.

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what is generalised anxiety?

Feeling tense, stressed, and worried at certain times when under pressure is a normal human response. In fact 2 out of every 5 people report that they worry at least once every day. However, for some people their worry, feelings of anxiety and tension persists to the point that they significantly interfere with their daily life. If this sounds like you, then you may find the information in this sheet very helpful in understanding what generalised anxiety is and its relevance to you.

What is Worry?

Before you can understand generalised anxiety, you need to have an understanding of worry. Worry is generally regarded as a form of verbal mental problem solving about potentially negative future events. It can be triggered by a variety of external events, or from thoughts that just pop into your head. Worry is characterised by a lot of "what if" statements such as:



- "What if I fail my exam?"
- "What if I can't do the job?"
- "What if I can't provide for my family?"
- "What if I get anxious during my interview?"

Normal worry is relatively short-lived and leads to positive problem-solving behaviour. Worry becomes unhelpful when it is about a number of things, is very frequent, and is difficult to control or dismiss. People may think this type of worry is useful, that it helps with problem solving and planning, or prevents future negative outcomes. However, this is not the case, as prolonged or frequent worry generates more anxiety and more worry, which may actually prevent positive thinking and action.

What are the key symptoms?

Generalised anxiety involves:

- **Anxiety or worry about several things** has occurred for at least the past 6-months
- The worry is experienced as excessive and uncontrollable, is present most days, and interferes with the ability to focus on tasks.

At least 3 of the following symptoms also need to be present for the past 6-months or longer:

- **Feeling restless**, keyed up, on edge & unable to relax
- **Physical tension**.
- **Sleep disturbance**. Having trouble falling asleep, maintaining sleep, or experiencing unsettled sleep.
- **Problems concentrating** and focusing on a task.
- **Feeling irritable**.
- **Feeling tired** or exhausted easily.

What are the causes?

The causes of generalised anxiety are not clearly understood. However, a number of vulnerabilities are considered to increase the chance of developing generalised anxiety:



- An inherited general biological disposition to experience negative emotions.
- Prolonged stress, and past experiences of uncontrollable or traumatic events.
- Direct or indirect messages from the people around you that the world is threatening or that worry is useful.
- A coping style that involves avoiding challenges or situations where there is the chance of experiencing negative emotions.

Diagnosis and Treatment

Generalised anxiety is not always easy to diagnose as some of its symptoms overlap with depression and other anxiety problems. It is thus important to see a mental health practitioner for a definite diagnosis.

The recommended psychological treatment for generalised anxiety is cognitive-behaviour therapy. This usually includes: relaxation to reduce chronic tension; techniques for dealing with unhelpful beliefs about worry; learning to challenge and let go of worries; learning more helpful coping and problem solving strategies; and learning to be less focused on uncertainty, and more present focused.



Mindfulness training and meditation may also be helpful for some individuals to reduce worry and increase present moment focus. However more research is required to determine if it is as effective as cognitive-behaviour therapy.

Thought Diary ³

A Activating Event

This may include an actual event or situation, a thought, mental picture or physical trigger.

B Beliefs

1. List all self-statements that link A to C. Ask yourself: "What was I thinking?" "What was I saying to myself?" "What was going through my head at the time?"
2. Find the most distressing (hot) thought and underline it.
3. Rate how much you believe this thought between 0 to 100.

C Consequences

1. Write down words describing how you feel.
2. Underline the one that is most associated with the activating event
3. Rate the intensity of this feeling between 0 to 100.

Unhelpful Thinking Styles

Do you recognise any unhelpful thinking styles you might have been using? (Mental filter, jumping to conclusions, personalisation, catastrophising, black & white thinking, shoulding & musting, overgeneralisation, labelling, emotional reasoning, disqualifying/ignoring positives)

4. Jot down any physical sensations you experienced or actions carried out.

D Detective Work & Disputation

Detective Work: Now refer to the hot thought, and ask yourself, "What is the factual evidence for and against my hot thought?"

My HOT Thought:	
Factual Evidence For My HOT Thought	Factual Evidence Against My HOT Thought

Disputation: Ask yourself the following questions ...

- What other ways are there of viewing the situation?
- If I were not feeling this way, how would I view the situation?
- Realistically, what is the likelihood of that happening?
- How might someone else view the situation?
- Does it really help me to think this way?
- Think of some helpful self-statements

E End Result

Balanced Thoughts: After looking at all the evidence for and against your hot thought, and having considered the disputation questions, replace the hot thought with helpful, balanced thought/s.

Re-rate Emotion: Now, re-rate the emotion you underlined in C, from 0 to 100. _____

Re-rate Hot Thought: Read through Detective Work & Disputation. Now re-rate how much you believe the hot thought, between 0 to 100. _____

Core Beliefs Worksheet

Core belief to be challenged:

Experiences that show that this belief is not COMPLETELY true ALL the time:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

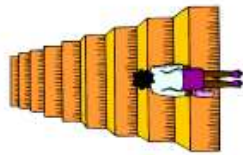
Balanced core belief:

Core belief to be tested:

Task/s:	Prediction:	What actually happened:
Conclusion:		
Balanced core belief:		

Situational Exposure Diary

Goal:



INSTRUCTIONS:

Use this sheet to record your progress on your steppladders.

You can describe:

- The step you were working on. What you did, when you did it (including how long it took).
- Your expected SUDS ratings – how nervous you expected to be.
- Your actual SUDS ratings – how nervous you *actually* were.
- Whether you completed the situation – if you were able to stay in the situation for the time you specified for that step, and what tools you used.
- If you experienced a great deal of difficulty. Note down why you think this might have been the case, and how you might prepare yourself to go into the situation the next time.

STEP/ SITUATION	Expected SUDS 0-100	Actual SUDS 0-100	Skills used to complete situation OR Difficulties with completion and skills to prepare for next situation

Thinking

Empty box for thinking notes.

Social Activities

Empty box for social activities notes.

Pleasant Activities

Empty box for pleasant activities notes.

Healthy



ME

Exercise

Empty box for exercise notes.

Relaxation

Empty box for relaxation notes.

Self-Care

Empty box for self-care notes.

Social Support

Empty box for social support notes.

Goals

Empty box for goals notes.

Self-Management Plan

You can type your responses below, or print this page out and write them in later.

What are the early warning signs that tell that I might be heading for a setback and need to do something about it myself? eg. Spending more time worrying about what others think **OR** I am spending more time avoiding situations **OR** I have more unhelpful thoughts than usual

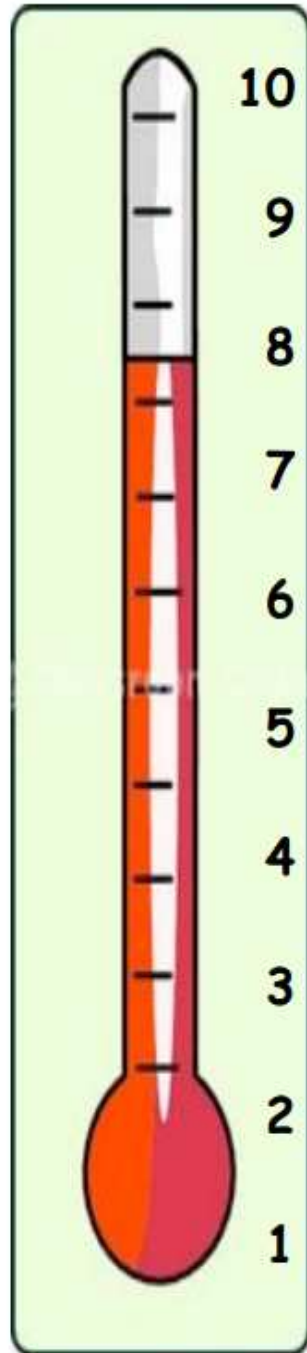
What are some of my unhelpful thinking styles that I need to watch out for?

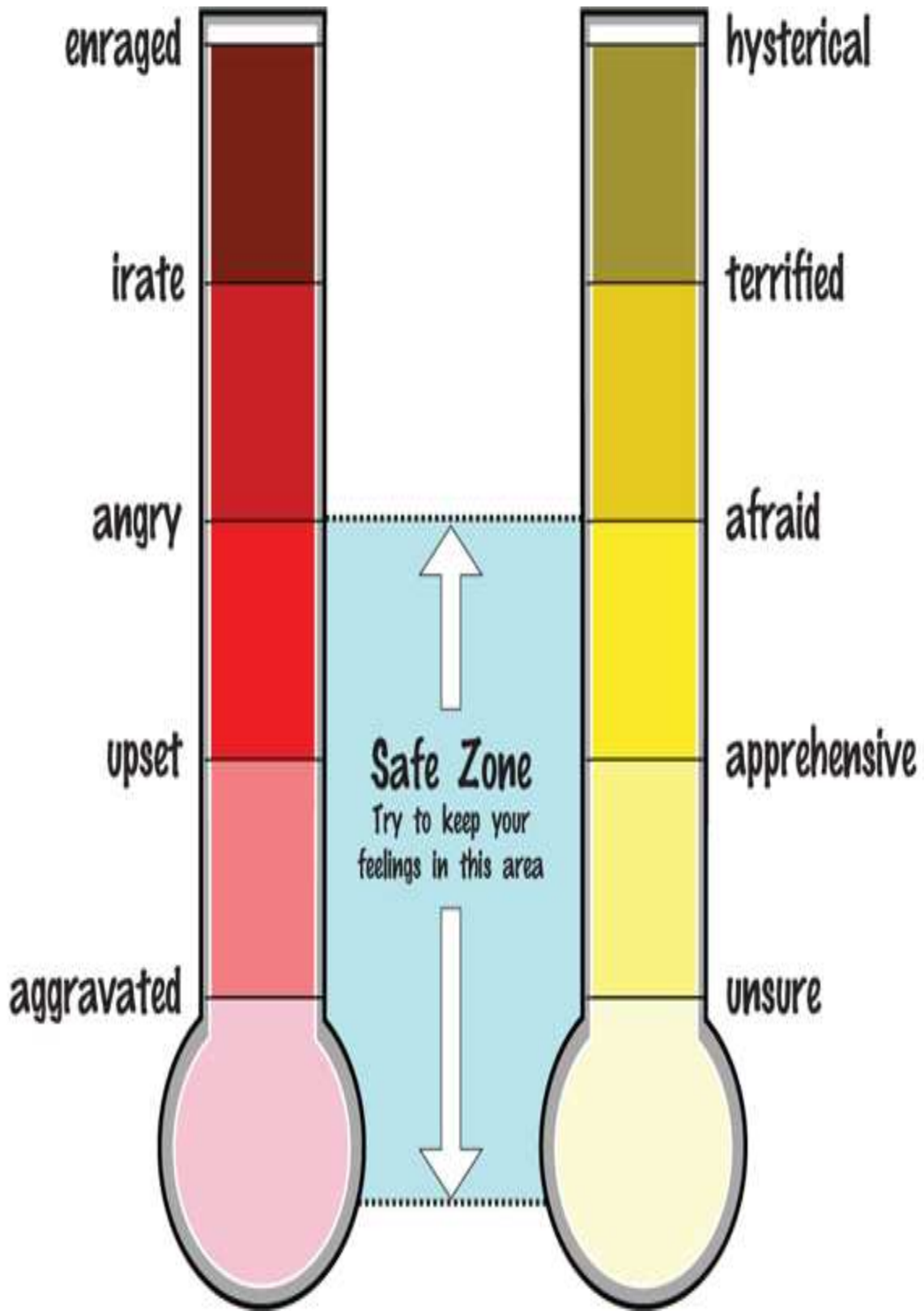
What situations are potential problems for me?

What are my future support options? eg Friends, family, GP, other...

What strategies/techniques have I found most helpful and need to continue to practise?

My Fear Thermometer





This STOP Plan is for:



Scared?

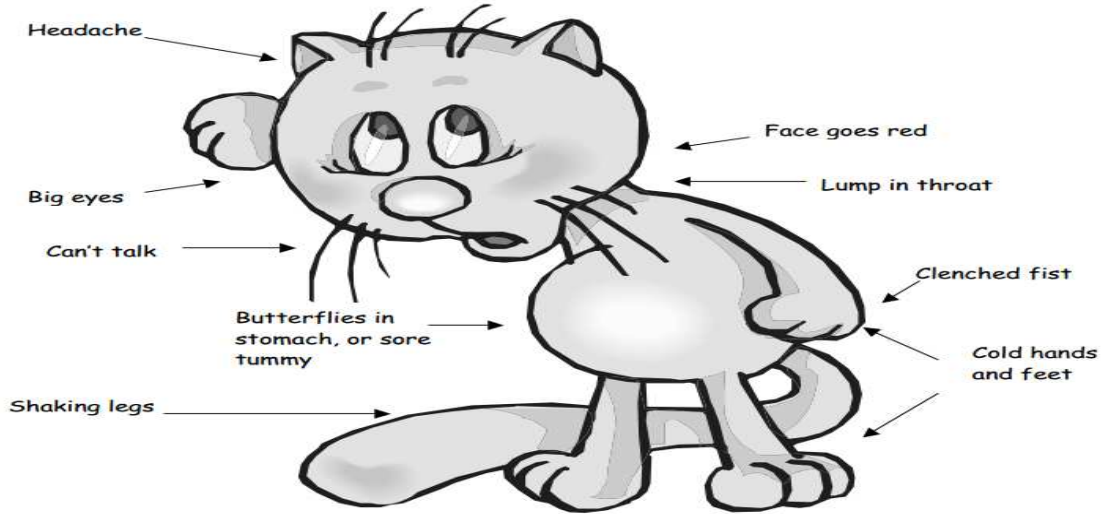
Thoughts?

Other helpful thoughts?

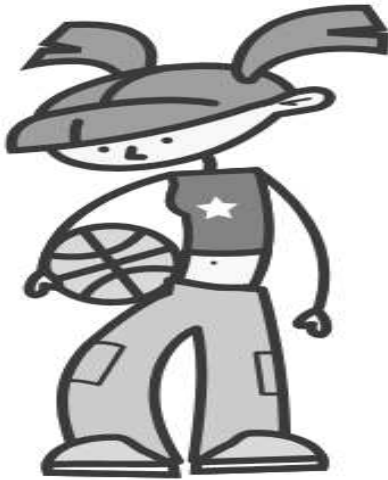
Praise and Plan!

<u>S</u>cared? <i>What's going on in your body?</i>	<u>T</u>houghts? <i>What are you thinking?</i>	<u>O</u>ther helpful Thoughts? <i>What is something <u>else</u> you can think?</i>	<u>P</u>raise and Plan! <i>What is something nice you can say to yourself? What can you do next time?</i>

Chester the Cat feels anxious!
How does Chester feel anxiety in his body?

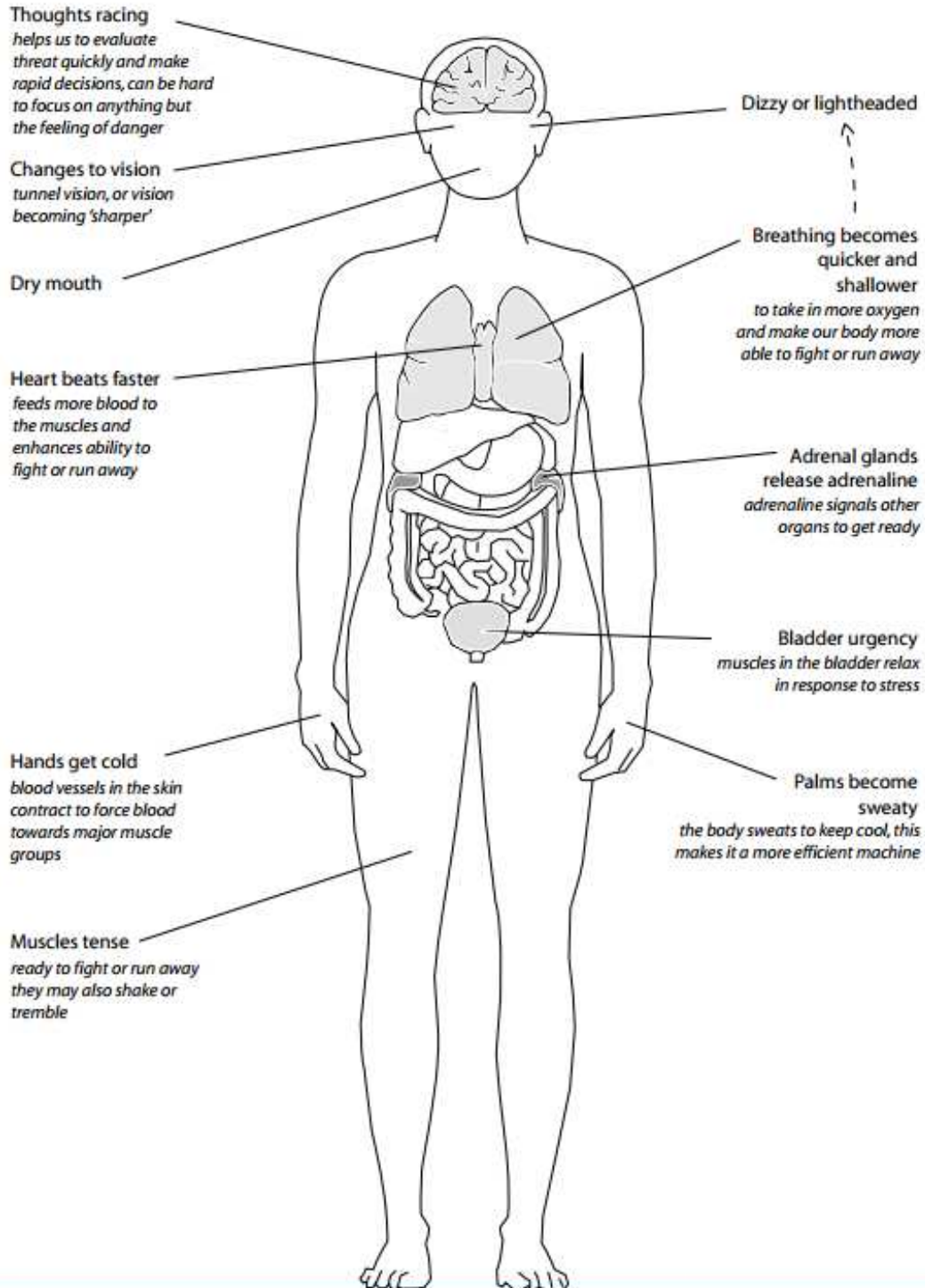


How do YOU feel anxiety in your body?



Threat System

The 'fight or flight' response gets the body ready to fight or run away. Once a threat is detected your body responds automatically. All of the changes happen for good reasons, but may be experienced as uncomfortable when they happen in 'safe' situations.



CONTINGENCY MANAGEMENT FOR PARENTS

REINFORCING AND REWARDING YOUR CHILD'S BEHAVIOR

_____ 's Reward Chart

I am working toward _____

Activity Day 1 Day 2 Day 3 Day 4 Day 5 Day 6 Day 7

Activity	Day 1	Day 2	Day 3	Day 4	Day 5	Day 6	Day 7

THINKING TRAPS

Thinking Traps	Examples
<p>Fortune-telling: This is when we predict that things will turn out badly. But, in reality, we cannot predict the future because we don't have a crystal ball!</p>	<p><i>"I know I'll mess up."</i></p> <p><i>"I will never be able to manage my anxiety."</i></p>
<p>Black-and-white thinking: This is when we only look at situations in terms of extremes. For example, things are either good or bad, a success or a failure. But, in reality, most events call for a more "moderate" explanation. For example, cheating once on your diet does not mean you have failed completely. You had a small setback, and all you need to do is to get back on your diet tomorrow.</p>	<p><i>"Anything less than perfect is a failure."</i></p> <p><i>"I planned to eat only healthy foods, but I had a piece of chocolate cake. Now my diet is completely ruined!"</i></p>
<p>Mind-reading: This trap happens when we believe that we know what others are thinking and we assume that they are thinking the worst of us. The problem is that no one can read minds, so we don't really know what others are thinking!</p>	<p><i>"Others think I'm stupid."</i></p> <p><i>"She doesn't like me."</i></p>
<p>Over-generalization: This is when we use words like "always" or "never" to describe situations or events. This type of thinking is not helpful because it does not take all situations or events into account. For example, sometimes we make mistakes, but we don't always make mistakes.</p>	<p><i>"I always make mistakes."</i></p> <p><i>"I am never good at public speaking."</i></p>
<p>Labeling: Sometimes we talk to ourselves in mean ways and use a single negative word to describe ourselves. This kind of thinking is unhelpful and unfair. We are too complex to be summed up in a single word!</p>	<p><i>"I'm stupid."</i></p> <p><i>"I'm a loser."</i></p>

<p>Over-estimating danger: This is when we believe that something that is unlikely to happen is actually right around the corner. It's not hard to see how this type of thinking can maintain your anxiety. For example, how can you not feel scared if you think that you could have a heart attack any time?</p>	<p><i>"I will faint."</i></p> <p><i>"I'll go crazy."</i></p> <p><i>"I'm dying."</i></p>
<p>Filtering: This happens when we only pay attention to the bad things that happen, but ignore all the good things. This prevents us from looking at all aspects of a situation and drawing a more balanced conclusion.</p>	<p><i>Believing that you did a poor job on a presentation because some people looked bored, even though a number of people looked interested and you received several compliments on how well you did.</i></p>
<p>Catastrophizing: This is when we imagine that the worst possible thing is about to happen, and predict that we won't be able to cope with the outcome. But, the imagined worst-case scenario usually never happens and even if it did, we are most likely able to cope with it.</p>	<p><i>"I'll freak out and no one will help."</i></p> <p><i>"I'm going to make such a fool of myself, everyone will laugh at me, and I won't be able to survive the embarrassment."</i></p>
<p>Should statements: This is when you tell yourself how you "should", "must", or "ought" to feel and behave. However, this is NOT how you actually feel or behave. The result is that you are constantly anxious and disappointed with yourself and/or with others around you.</p>	<p><i>"I should never feel anxious."</i></p> <p><i>"I must control my feelings."</i></p> <p><i>"I should never make mistakes."</i></p>

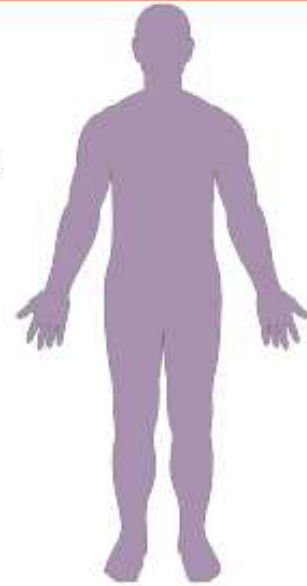
CHALLENGE NEGATIVE THINKING

Questions to ask yourself to help challenge your negative thoughts or self-talk:

- Am I falling into a thinking trap (e.g., *catastrophizing* or *overestimating danger*)?
- What is the evidence that this thought is true? What is the evidence that this thought is not true?
- Have I confused a thought with a fact?
- What would I tell a friend if he/she had the same thought?
- What would a friend say about my thought?
- Am I 100% sure that _____ will happen?
- How many times has _____ happened before?
- Is _____ so important that my future depends on it?
- What is the worst that could happen?
- If it did happen, what could I do to cope with or handle it?
- Is my judgment based on the way I feel instead of facts?
- Am I confusing "possibility" with "certainty"? It may be possible, but is it likely?
- Is this a hassle or a horror?

PROGRESSIVE MUSCLE RELAXATION SCRIPT

1. Take three deep abdominal breaths, exhaling slowly each time, imagining the tension draining out of your body.
2. Clench your fists. Hold for 10 seconds, before releasing and feeling the tension drain out of your body (for 15 seconds).
3. Tighten your biceps by drawing your forearms up toward your shoulders and make a muscle with both arms. Hold, then relax.
4. Tighten your triceps (the muscles underneath your upper arms) by holding out your arms in front of you and locking your elbows. Hold, then relax.
5. Tense the muscles in your forehead by raising your eyebrows as high as you can. Hold, then relax.
6. Tense the muscles around your eyes by clenching your eyelids shut. Hold, then relax. Imagine sensations of deep relaxation spreading all over your eyes.
7. Tighten your jaws by opening your mouth so widely that you stretch the muscles around the hinges of your jaw. Hold, then relax.
8. Tighten the muscles in the back of your neck by pulling your head way back, as if you were going to touch your head to your back. Hold, then relax.
9. Take deep breaths and focus on the weight of your head sinking into whatever surface it is resting on.
10. Tighten your shoulders as if you are going to touch your ears. Hold, then relax.
11. Tighten the muscles in your shoulder blades by pushing your shoulder blades back. Hold then relax.
12. Tighten the muscles of your chest by taking in a deep breath. Hold, then relax.
13. Tighten your stomach muscles by sucking your stomach in. Hold, then relax.
14. Tighten your lower back by arching it up (don't do this if you have back pain). Hold, then relax.
15. Tighten your buttocks by pulling them together. Hold, then relax.
16. Squeeze the muscles in your thighs. Hold, then relax.
17. Tighten your calf muscles by pulling your toes towards you. Hold, then relax.
18. Tighten your feet by curling them downwards. Hold, then relax.
19. Mentally scan your body for any left over tension. If any muscle group remains tense, repeat the exercise for those muscle groups.
20. Now imagine a wave of relaxation spreading over your body.



Behavior Contract

I, _____, agree to make the following positive behavior changes:

My efforts at meeting this goal will be considered complete when:

When I successfully complete this contract, I will be rewarded by:

Student signature: _____

Teacher signature: _____

Parent signature: _____

Other school staff signature: _____

Date: _____

Parent Worksheet

What behavior will you begin with this week?

Write the rule clearly and specifically.

Explain how you will supervise your child to have success with this rule.

Remember: You must CONSISTENTLY ENFORCE THE RULE.

What will you say to your child when they complete the task?

DATE	Rule Followed: YES / NO	COMMENTS

How To Make A Rule / Parent Education Worksheet

How to get your child to behave:

- Make a rule about a specific behavior
- Supervise (follow through)
- Be consistent

What is a Rule?

A rule is really a demand which is both *clearly* and *directly* stated. A rule tells another person the following 3 things:

- ❖ *what* to do (or what not to do)
- ❖ *when* to do it (or when not to do it)
- ❖ for *how long* and/or how often

Examples of good rules:

- Take the trash out every night right after dinner from now on.
- Get out of bed every school day morning at 6:00 A.M. from now until you graduate.
- Hang up all of your clothes every night before you go to sleep from now on.

It is difficult to break old and ineffective communication habits. Here are some Examples of statements that parents use that are not clearly/directly stated. These are NOT good rules...Can you determine why they are not effective?

1. Please take out the trash.
2. You need to do your homework.
3. Be good in school today.
4. Remember to bring your homework home.
5. Put the dishes away, okay?
6. I wish you would make your bed every day.
7. Why did you hit your brother?
8. If you don't clean your room you can't watch T.V.

Practice: Make your own rules for the following problem areas.

A. Bedtime: _____

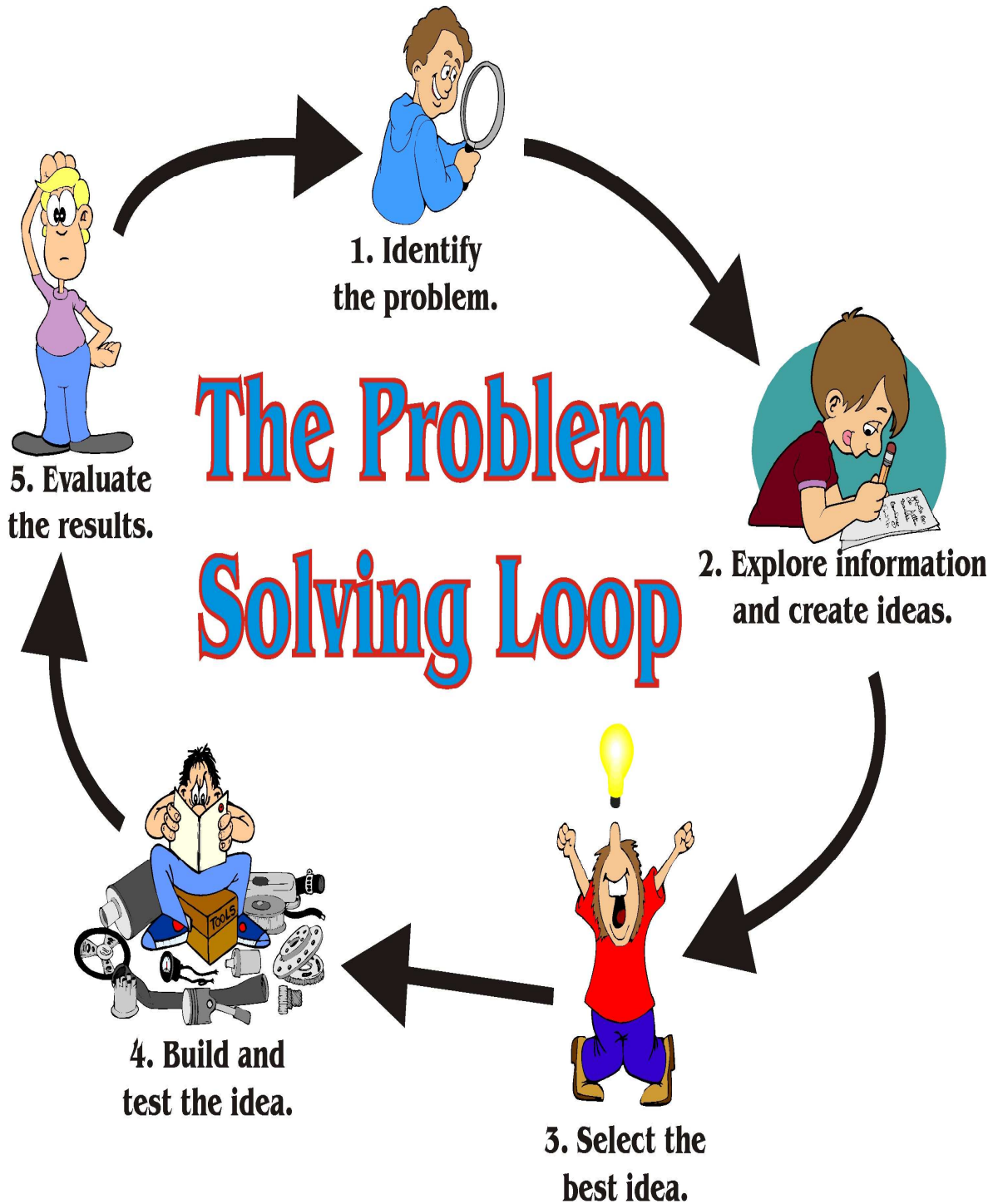
B. Chores: _____

C. School Behavior: _____

Summary of Basic Principles

1. **Focus on a problem of behavior.** If you are feeling angry or upset think about it and determine exactly what behavior you would like to change.
2. **Make a rule about the problem behavior.** Give very simple and clear directions:
“Pick up all of your toys now and every morning before breakfast.”
“Complete all of your homework problems right now.”
3. **Do not allow yourself to engage in an argument with the child. Instead, avoid discussion** and say,
“*Regardless*, complete you assignment right now.”
“*Nevertheless*, pick up all of your toys right now.”
4. **If the child continues to argue, absorb the argument by saying,**
“un huh...” “emm huh...” “...is that it?”
5. **Do not raise your voice. Stay in control.** Give directions in a strong yet determined voice.
6. **It is essential to give this child as much direct supervision as possible.** Stand or sit next to the child and convey by your body language and tone of voice that you mean what you are saying and that your direction must be obeyed. You send this message with **firmness, not anger**. You want to convey to this child that right now you are “not a person to mess with” and you mean business!
7. **This child may have a way of “pushing your buttons” or cause you to lose your patience.** Try to identify behaviors that bother you. Make rules about them. Supervise consistently until the behavior diminishes.
8. **Never “take the bait.”** Never argue with the child. Only respond by repeating the rule, or “regardless,” or “nevertheless,” and using sponge.
9. **To avoid punishment, closely supervise and “force him/her to succeed.”**
10. **It is important to be consistent.** If the child never gets away with a negative behavior they will stop trying. If, however, every so often they get away with that behavior it can become like a game to see if they can do it again. They will not believe that you mean what you say.
11. **Praise that child when he/she succeeds.** Reward him/her with your love and affection.
“*Good Job!*” ... “*I am so proud of you.*” ... “*I love you.*”
Words like this mean everything to your child.

THE PROBLEM SOLVING MODEL



**SCHOOL REFUSAL BEHAVIOR – A TREATMENT MAP AND MANUAL
CULMINATING PROJECT EVALUATION**

Evaluator: Carmen Ortez, Bilingual School Psychologist, Nationally Certified School Psychologist

Date: 07/21/2012

1. Overall, was the information presented in the manual helpful to you if you wanted to offer an intervention to students refusing school?

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

2. Would having a treatment manual available increase the likelihood that you would offer intervention services to school refusing students? *Having the manual handy is definitely extremely helpful and valuable; however, other components often come into play (e.g., additional job responsibilities); however, it would be easier to delegate to other team members in order to assist students.*

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

3. In your experience, would you agree that the practices listed in the manual are evidence-based practices? *Absolutely.*

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

4. I feel that the worksheets will be helpful in working with elementary school aged students. *The worksheets use child-friendly vocabulary and are easy for young children to understand.*

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

5. I feel that the worksheets will be helpful in working with middle school and high school aged students. *Although the worksheets use child-friendly language, they are appropriate for secondary students as well. Tonya had the opportunity to work with K-12th students at the same school setting and did a wonderful job gauging how to assess the needs of students across varied age levels.*

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
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6. Do you feel that identifying underlying stressors for anxiety / negative-affect driven school refusal behavior is an important starting point for reducing school refusal? Why? Absolutely. At my current work site (K-12th), we primarily see school refusal with the older children (secondary, approximately age 14 and on) and without really understanding the underlying issues impacting their behavior, it is a challenge for both family and school staff to assist them.

7. Do you feel that imaginal exposure is a necessary prerequisite step before in-vivo exposure when treating anxiety disorders? Why? I do not have sufficient knowledge regarding imaginal exposure. However, given the symptoms experienced by individuals with anxiety disorders, it appears to be best practice.

8. Do you feel that 12 weeks is adequate for treating anxiety / negative-affect driven school refusal behavior? I think this will vary depending on individual student needs. Initially, 12 weeks appears appropriate for providing support for these individuals. At 12 weeks, and throughout the 12 weeks of service, the student's needs should be evaluated to determine if additional assistance is needed past twelve weeks. In Addition, other resources on campus should be put in place (e.g., modified assignments, extended time, Student Success Team meeting, etc.) to assist with the student's success at school.

9. What kind of improvements or suggestions would you make to improve the treatment plan for anxiety / negative-affect driven school refusal, if any? N/A. This plan appears well developed.

10. Do you feel that parent training and contingency management will be effective in reducing school refusal behavior for students who refuse school because they are seeking tangible rewards outside of school? Why? Absolutely. Regardless of the situation, parent training is valuable in general. However, in this particular case, parents will require additional information to better understand what are appropriate tangible, as well as intangible rewards that are reasonable for the family. A specific plan should be clearly developed with the parents to set clear goals/expectations and revisited regularly and modified as needed.

11. Do you feel that it's important to get parent involvement and support for interventions provided to students? Yes. Parents are an essential part of treatment for students and this allows for consistency (or an attempt at consistency) between home and school, which will hopefully lead to student success.

11. Do you think that student contracts would be beneficial in improving student attendance for school-refusing students? Again, this will be based on individual student needs and preferences. I have found this to be very useful with both elementary and secondary students, yet they can be useless when there is no follow-through at home or the person in charge of monitoring/rewarding the contract is inconsistent.

12. Do you think successful student contracting might generalize to other student behavior and beliefs, for example, it might increase student self-efficacy and self-advocacy skills? Yes. Again, this will vary depending on the student, but we have seen positive responses at home and at school utilizing these methods.

Thank you for responding.

refusal behavior? No. While some symptom reduction may be gained in this short time through exposure and relaxation, it is not enough time to look into underlying factors of environment which may also contribute to the behaviors.

9. What kind of improvements or suggestions would you make to improve the treatment plan for anxiety / negative-affect driven school refusal, if any? This is a good treatment plan, but it may be useful for students to also spend additional time with a school counselor in order to get a more complete picture of the child's environment at home and at school.
10. Do you feel that parent training and contingency management will be effective in reducing school refusal behavior for students who refuse school because they are seeking tangible rewards outside of school? Why? Yes. I believe parents need to understand how they may be contributing to the school refusal behavior by providing attention or other tangible rewards to the child when he/she is out of school.
11. Do you feel that it's important to get parent involvement and support for interventions provided to students? I think it is very important to get parent involvement, however, I know there are instances when this may not be possible.
12. Do you think that student contracts would be beneficial in improving student attendance for school-refusing students? I think this depends upon the individual student and level of parent support.
13. Do you think successful student contracting might generalize to other student behavior and beliefs, for example, it might increase student self-efficacy and self-advocacy skills? It's possible, but I don't have enough information to say one way or the other.

Thank you for responding.

**SCHOOL REFUSAL BEHAVIOR – A TREATMENT MAP AND MANUAL
CULMINATING PROJECT EVALUATION**

Evaluator: Rebecca Rufer, Licensed Marriage and Family Therapist

Date: 07/23/2012

1. Overall, was the information presented in the manual helpful to you if you wanted to offer an intervention to students refusing school?

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

2. Would having a treatment manual available increase the likelihood that you would offer intervention services to school refusing students?

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

3. In your experience, would you agree that the practices listed in the manual are evidence-based practices?

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

4. I feel that the worksheets will be helpful in working with elementary school aged students.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

5. I feel that the worksheets will be helpful in working with middle school and high school aged students.

Strongly Agree	Agree	Neutral	Disagree	Strongly Disagree
1	2	3	4	5

6. Do you feel that identifying underlying stressors for anxiety / negative-affect driven school refusal behavior is an important starting point for reducing school refusal? Why? **Yes because by starting with an investigation of the underlying factors that drive a particular student's school refusal, providers work to change the social/interpersonal environment that is supporting a student's school refusal and thereby increase attendance.**

7. Do you feel that imaginal exposure is a necessary prerequisite step before in-vivo exposure when treating anxiety disorders? Why? **Not necessarily. It would depend on the client's current ability to self-regulate as well as the client's perceived intensity of the stressor. (ex. I would practice imaginal and then in vivo with a client who reported being terrified of lizards but I may not do that with a client who demonstrated appropriate self-regulation**

abilities and reported being nervous, uncomfortable, and avoidant of lizards)

8. Do you feel that 12 weeks is adequate for treating anxiety / negative-affect driven school refusal behavior? It depends. Firstly, children who are engaging in school refusal behaviors will also probably be engaging in those same behaviors during their school-refusal treatment which impacts the efficacy of the treatment. In my experience it is difficult to get non-participating students to invest in the therapeutic process right off the bat and attend session regularly. It usually has taken me about 2 weeks to one month to build rapport with children/adolescents and get them and/or their parents to feel invested in attending therapy on a consistent and regular basis. So for that reason I would extend the time to a timeframe that would allow for a one-month rapport building window. Say 16-weeks.
9. What kind of improvements or suggestions would you make to improve the treatment plan for anxiety / negative-affect driven school refusal, if any? I would teach relaxation skills as one of the first interventions (after assessment and psycho-education) so that the client could immediately begin to build the skills necessary to regulate their affect and I would include more interventions than just the progressive muscle relaxation. Such as guided imagery, deep breathing exercises, etc.
10. Do you feel that parent training and contingency management will be effective in reducing school refusal behavior for students who refuse school because they are seeking tangible rewards outside of school? Why? Yes because parents are the ones most able to directly impact the students behaviors and increase compliance. Also it builds the parents ability to handle difficult parenting situations and works on improving the relationship between parent and child (a relationship that is often strained when children are engagin in school-refusal)
11. Do you feel that it's important to get parent involvement and support for interventions provided to students? Yes for the reasons explained above.
12. Do you think that student contracts would be beneficial in improving student attendance for school-refusing students? Maybe but in my experience contracts are only effective if the student feels like a stakeholder in the process and that that feeling of being a stakeholder is often impeded when an older, authoritative adult is giving them a piece of paper and getting them to sign a "Behavioral Contract".
13. Do you think successful student contracting might generalize to other student behavior and beliefs, for example, it might increase student self-efficacy and self-advocacy skills? Maybe. Certainly I believe that most student's sucessfully completing any explicitly worked for goal will feel "proud/better about themselves" which could act as a support for increasing self-efficacy.

Thank you for responding.

SCHOOL REFUSAL BEHAVIOR – A TREATMENT MAP AND MANUAL

CULMINATING PROJECT EVALUATION

1. Overall, was the information presented in the manual helpful to you if you wanted to offer an intervention to students refusing school?

Strongly Agree 1 Agree 2 Neutral 3 Disagree 4 Strongly Disagree 5

2. Would having a treatment manual available increase the likelihood that you would offer intervention services to school refusing students?

Strongly Agree 1 Agree 2 Neutral 3 Disagree 4 Strongly Disagree 5

3. In your experience, would you agree that the practices listed in the manual are evidence-based practices?

Strongly Agree 1 Agree 2 Neutral 3 Disagree 4 Strongly Disagree 5

4. I feel that the worksheets will be helpful in working with elementary school aged students.

Strongly Agree 1 Agree 2 Neutral 3 Disagree 4 Strongly Disagree 5

5. I feel that the worksheets will be helpful in working with middle school and high school aged students.

Strongly Agree 1 Agree 2 Neutral 3 Disagree 4 Strongly Disagree 5

6. Do you feel that identifying underlying stressors for anxiety / negative-affect driven school refusal behavior is an important starting point for reducing school refusal? Why?

- / -

Yes. Until underlying stressors are looked at to see if, and how, they are impacting school refusal behavior, it will be hard to design interventions. Certainly anxiety and negative-affect are important factors to look at initially.

7. Do you feel that imaginal exposure is a necessary prerequisite step before in-vivo exposure when treating anxiety disorders? Why?

Yes. When using exposure interventions, grading exposure is important in order not to flood the child. Imaginal exposure is a less anxiety-provoking intervention so should be used first before attempting in-vivo exposure.

8. Do you feel that 12 weeks is adequate for treating anxiety / negative-affect driven school refusal behavior?

It depends on the child and the difficulties that the child faces in terms of individual traits and environmental factors. 12 weeks will not always be enough time.

7. What kind of improvements or suggestions would you make to improve the treatment plan for anxiety / negative-affect driven school refusal, if any?

I would want to incorporate sessions with the parents (without the child) to help the parents see if and how they are contributing to the problem behavior as well as to make sure the parents are supportive of what and how the child is trying to improve/change. Additionally, I would recommend family sessions. Since the family environment will most likely be playing a significant role in anxiety/negative-affect driven school refusal, it would be important to work with the family "system" as well as the individual student.

9. Do you feel that parent training and contingency management will be effective in reducing school refusal behavior for students who refuse school because they are seeking tangible rewards outside of school? Why?

Yes. Parent training is essential, since in most cases the family system will be playing a significant role in supporting school refusal behavior. Contingency management where the parents establish structure/rules with specific rewards and punishments have been demonstrated to be highly effective.

10. Do you feel that it's important to get parent involvement and support for interventions provided to students?

Yes, it's critical. Much of student misbehavior can be directly attributable to the family system. Parental involvement and support is critical in order to provide the right support for the child to be able to change.

11. Do you think that student contracts would be beneficial in improving student attendance for school-refusing students?

Yes, especially if the parents are involved in the contract process. The more the child can be accountable to his/her parents and the school in a clear way, the better the likelihood of change.

12. Do you think successful student contracting might generalize to other student behavior and beliefs, for example, it might increase student self-efficacy and self-advocacy skills?

Generalizing contracts to other student behaviors and beliefs might be very beneficial, especially if parents are involved in the contracting process, for the same reason it can be helpful in the problematic behaviors addressed in this thesis. Accountability, especially to the family system, and goal specificity across a wide range of behaviors and beliefs would most likely result in improved student self-efficacy and self-advocacy.

Joe Nobel, LMFT

Thank you for responding.

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