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Bridging the Gap Between Assessment and Treatment of Youths with School Refusal Behavior: What to do When Clients Ask “What Now?”

Marisa Hendron
Christopher A. Kearney
University of Nevada, Las Vegas

Youths with school refusal behavior present a vexing but common problem for psychologists. School refusal behavior is a child-motivated refusal to attend school or difficulties remaining in classes for an entire day. School refusal behavior may involve complete or partial absences from school, chronic tardiness, morning misbehaviors in an attempt to miss school, or substantial distress at school that precipitates pleas for future nonattendance (Kearney & Silverman, 1996). School refusal behavior is a part of problematic school absenteeism that includes youths who (1) have missed at least 25% of total school time for at least 2 weeks, (2) experience severe difficulty attending classes for at least 2 weeks with significant interference in a youth's or family's daily routine, and/or (3) are absent for at least 10 days of school during any 15-week period while school is in session, with an absence defined as 25% or more of school time missed on a particular day (Kearney, 2008a).

A comprehensive community survey of youths with anxiety-based school refusal and truancy revealed a prevalence rate of 8.2% (Egger, Costello, & Angold, 2003), though others have noted that the prevalence of all school refusal behaviors may be as high as 28-35% (Kearney, 2001; Pina, Zerr, Gonzales, & Ortiz, 2009). Reviews of characteristics of this population and the adverse consequences of absenteeism are available (Carroll, 2010; Henry, 2007; Henry & Huizinga, 2007; Heyne, King, Tonge, & Cooper, 2001; Kearney, 2008a; King & Bernstein, 2001; Yahaya et al., 2010).

Cases of school refusal behavior can be complicated, but

Summary

Cases involving school refusal behavior in youth are often demanding, time-consuming, and urgent. Many clients query a clinician about procedures they can implement immediately following consultation or assessment and prior to formal treatment. This article helps address this gap by providing clinicians with specific recommendations that they can make immediately to parents, youths, and school-based personnel regardless of the individual characteristics of a given case.

Keywords

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Contact

Christopher A. Kearney
Department of Psychology
University of Nevada,
Las Vegas
4505 Maryland Parkway
Las Vegas, NV 89154-5030
Telephone: (702) 895-0183
Fax: (702) 895-0635
chris.kearney@unlv.edu

assessment and treatment protocols for this population have been developed and tested. These protocols generally include a behavioral assessment approach as well as cognitive-behavioral and family-based interventions to help youths return to school with less distress (see Bernstein et al., 2000; Heyne et al., 2002; Kearney & Silverman, 1999; King et al., 1998; Last, Hansen, & Franco, 1998). A functional analytic approach to identify and address the maintaining variables of school refusal behavior has been elaborated (Kearney, 2007a; Kearney & Albano, 2007a). School refusal behavior can be linked to many contextual factors as well, and clinicians are encouraged to explore contributing child-, parent/family-, peer-, school-, and community-based factors (Kearney, 2008b).

Clinicians may encounter school refusal behavior in youths as a primary issue or a secondary one embedded in larger problems such as an anxiety, mood, or disruptive behavior disorder as well as family, school, and community crises (Kearney & Albano, 2004, McShane, Walter, & Rey, 2001; Thambirajah, Grandison, & De-Hayes, 2008). In either scenario, reducing school absenteeism is often the most urgent and palatable treatment target for parents and school officials. Parents are often under considerable pressure to return a child to school quickly or face legal ramifications, missed work, increased family conflict, and a child's academic failure, among other problems. In turn, clinicians often find themselves under considerable pressure from parents and sometimes school officials to implement procedures quickly to reduce absenteeism.

Much of this pressure comes immediately after the screening or initial assessment process when parents want to know what to do *the next morning*. Such a demand often does not match well with a clinician's schedule or the need to collect more information or collate information to devise a more intricate treatment plan. Unlike many cases that clinicians see, parents of youths with school refusal behavior often immediately ask "What now?" The purpose of this article is to provide clinicians with specific recommendations to answer this question, bridge the gap between the screening/assessment process and initiation of formal intervention, and lay some groundwork for successful treatment outcome.

A Case Example

Isabella (contrived name) was an 11-year-old female in middle school who was reportedly nervous and scared about attending school, with a particular fear of classmates vomiting near her in class or on the school bus. She met criteria for Specific Phobia but no other diagnosis, and her scores on general fear and anxiety measures were largely in the normal range. She enjoyed visiting the counselor's office during the day as well. Isabella's absentee problems had gradually worsened over the course of the school year, she had 14 documented absences at the time of her assessment in early March, and she had not been at school since mid-February. She insisted on remaining home from school and was accommodated by her parents in this regard.

Isabella's parents endorsed dual functions of their daughter's school refusal behavior: attention-seeking behavior and avoidance of school-related stimuli that provoked negative affectivity. They also reported that Isabella was not maintaining her academic work and was in danger of lowered grades. Isabella's parents indicated they were facing increased pressure from school officials to return their daughter to school, and requested immediate help during the assessment process. Such requests are common to this population. A series of "nuts and bolts" recommendations (see Table 1) for what therapists may wish to consider when faced with such requests early in the clinical process is thus presented next.

Contact with School Officials

Clinicians should encourage parents to maintain regular, preferably daily, contact with key officials such as a school psychologist, school-based social worker, guidance counselor, principal, or teacher. Many schools will have a “point person” assigned the task of consulting with families whose child refuses school. The point person in Isabella’s case was her guidance counselor, who served as liaison between Isabella’s parents, school administrators and the therapist. Important points of early parent-school official discussion should include the child’s pattern of school absences, current academic status and past and present assignments, level of distress at school, and interactions with others such as peers and teachers, as well as related behavior problems. Parents and school officials must also be synchronized with respect to understanding the consequences of continued absenteeism, school policies regarding absenteeism, a timeline for reintegrating the child to school, and anticipated obstacles to doing so.

Increased communication will hopefully ease parent-school official tensions as well, which often mark these cases. Such communication can come in the form of daily emails, telephone conversations, and daily progress notes sent home by teachers if relevant. Parents should also convey to school officials that they are pursuing treatment for their child’s school refusal behavior. In our experience, school officials are generally much more tolerant of absentee cases when they know parents are actively working toward a solution. This often translates into a delayed referral to a juvenile justice agency for violation of a school district’s attendance policy or for educational neglect.

Parents may also wish to consider informing school officials of the name and contact information of their therapist. An open dialogue with the therapist, especially early on to complete the assessment process and plan the reintegration process, is often crucial. Isabella’s therapist, for example, worked closely with the guidance counselor to discuss a partial morning attendance plan and defer a truancy citation. However, we also recommend reinforcing boundaries with these

Table 1.

Recommendations after Assessment and before Formal Treatment of School Refusal Behavior

- Maintain regular contact with key school officials to discuss absenteeism and academic and other issues
- Ask parents to secure academic work from teachers for the child to complete while at home
- Have parents maintain a regular morning routine that includes school preparation behaviors
- Begin initial school reintegration process by focusing on what the child is willing to attend
- Ask parents to pursue appointments as needed with other professionals such as pediatricians or probation officers
- Implement close supervision of the child’s attendance to prevent more extensive absenteeism
- Mobilize parents’ social support network for help getting a child to school
- Maintain a daily record of attendance, distress, and behavior problems before school
- Provide psychoeducational materials to parents and school officials regarding school refusal behavior

cases, as many parents will seek to contact the clinician or school officials multiple times a day and during early morning hours when school preparation occurs.

Obtain Homework or Other Academic Work

Isabella's parents expressed concern about the impact of their daughter's absenteeism on her academic performance and grades. If a child is not currently in school, he or she should complete academic work while at home. Doing so serves several purposes, including maintaining a child's grades, easing the eventual transition back to class, preserving some semblance of a school day, and preventing unhelpful behaviors such as playing videogames, attention-seeking, or being with friends during school hours. Parents can thus be encouraged to secure current homework or make-up work from teachers or ask a guidance counselor or other school official to secure a package of work from teachers. Parents or others will need to closely supervise and reward the child's academic work at home while minimizing attention for nonacademic activities. Isabella's guidance counselor agreed to contact teachers, ask them to send assigned work to her office each day Isabella was out of school, and give the work to Isabella's parents.

Maintain a Regular Morning Routine

An extremely important aspect of building success toward regular school attendance will be a structured and orderly morning routine to prepare for school. Parents sometimes lapse into letting a child who is missing school stay up late at night and rise late in the morning. Instead, parents should be encouraged immediately to restart the implementation of a regular bedtime and morning routine. The morning routine should be implemented even if a child is not attending school and may consist of set times for rising from bed, eating breakfast, getting dressed, and other normal preparation activities (as well as rewards for compliance and disincentives for noncompliance). Parents may even be willing to drive their child to school and stay in the parking lot for some time to reinforce the school preparation process. Isabella's treatment began shortly before a scheduled spring break, which gave her parents a good opportunity to reinstate set schedules for bedtime, wake time, and steps for school preparation in the morning.

Part-Time Attendance Schedule

Many children currently absent from school are willing to attend certain classes or attend school under limited conditions. Clinicians should determine during assessment what a child can or is willing to approach with respect to school attendance and then utilize this as a baseline. This can occur in several ways. First, some children say they prefer certain classes and would be willing to attend only those. Parents should thus contact the relevant school official to see if a child could attend only 1-2 specific classes or lunch. Second, some children are able to attend school for some time in the morning or afternoon, so this could be arranged as well.

Third, some children are able to stay in a non-classroom part of school, such as the library, a great room, another catchment area, or a counselor's office (like Isabella). The school reintegration process will be greatly facilitated if a child is attending at least some time at school and has exposure to academic work and interactions with teachers and peers. Clinicians could also encourage parents to begin work with school officials to devise a formal specialized plan if necessary to accommodate a modified schedule with the understanding that full-time attendance in a regular classroom setting is the eventual goal. Isabella did not have such a plan but was able to initially complete work under supervision in the school library.

Appointments with Other Professionals and Contact Information

Another activity that parents may engage in during the transition from assessment to treatment is to pursue appointments with other professionals as necessary. Many cases of school refusal behavior involve somatic complaints such as headaches and stomachaches (Bernstein et al., 1997), so clinicians may encourage parents to see their pediatrician to identify, rule out, and/or treat physical causes of these symptoms. Other youths with school refusal behavior may require meetings with a psychiatrist, case worker, or probation officer depending on their medical or legal status. Parents may be encouraged as well to consult an attorney if substantial risk exists that a referral to truancy court or a juvenile detention agency will be made by school officials.

Another immediate activity that parents may engage in is to solicit contact information from all parties relevant to the school refusal case, including those professionals named above. These cases often demand frequent consultation, feedback, and negotiation among parents, various school officials, and the clinician. Cell phone numbers and email addresses are important when the need exists to transfer information quickly, such as when a child will be late to school or has inappropriately and prematurely left school. Isabella's mother was able to reach the therapist via cell phone and email, which was beneficial for quickly conveying information from the school and for adjusting therapeutic procedures as necessary.

Prevent Related Behaviors

A key goal between assessment and treatment of school refusal behavior is to ensure that the problem does not dramatically worsen or deteriorate, which can happen quickly. We strongly urge parents to immediately implement close supervision of their child, which may include finding a child who prematurely departed the school campus. Immediate efforts that parents can do to disrupt their child's deviant peer networks, delinquent activities, or other lures toward absenteeism are encouraged as well and will pay dividends later. Parents should also be asked to begin developing a list of potential incentives and disincentives that may be useful for rewarding attendance and discouraging absenteeism.

Parents should also begin marshaling resources needed to address their child's school refusal behavior. This may come in the form of leave time from work, mobilizing their social support network to provide assistance, arranging a child's transportation to and from school, and organizing people to escort a child to school and perhaps from class to class. Parents may begin to contact extended relatives, neighbors, friends, and church members in this regard. Isabella's parents were able to take advantage of flexible work schedules to bring their daughter to school and escort her where necessary.

Daily Assessment

Parents and children should be asked immediately to maintain a daily record of the child's attendance and other key variables related to their case. Records are available for this population (Kearney & Albano, 2007a), but one can be devised quickly for daily monitoring of number of hours in school (and class), ratings of distress on a 0-10 scale, and behavior problems demonstrated in the morning before school. In addition, if a child is in school at least part-time, then attendance journals are useful means of verifying presence in class. These journals require the child to solicit a teacher's signature to confirm attendance. Isabella's attendance and resistance to attending school were monitored daily.

Daily assessment serves multiple purposes for this population. First, the assessment provides the clinician with valuable baseline information as well as the degree of compliance to be expected from the family. Second, the child's pattern of attendance and distress and noncompliance can be noted, and therapeutic resources may be assigned accordingly. For example, many children have difficulties attending school on Mondays or from 6:00-8:45 a.m., which helps identify where a clinician would focus techniques such as anxiety or contingency management. Finally, daily assessment increases awareness of the school refusal problem for all parties and sometimes spurs spontaneous action to induce greater attendance.

Psychoeducational Materials

Parents and children will also benefit from reading about and preparing for upcoming therapeutic procedures. Psychoeducational materials in the form of self-directed books, parent manuals, and scholarly papers regarding school refusal behavior may be helpful in this regard (see Csoti, 2003; Eisen & Engler, 2006; Kearney, 2007b, 2008b; Kearney & Albano, 2007b). This assignment has the added benefit of assessing a family's willingness to engage in substantial work to resolve the absentee problem and to foreshadow the substantial work that will be required for resolution. Psychoeducational materials are also helpful for relieving a family's sense of isolation and uniqueness regarding the school refusal behavior. Efforts on the part of the clinician to inform the family that school refusal behavior is a common problem are encouraged as well.

Many school officials, particularly those addressing a case of school refusal behavior for the first time, commonly ask for bibliographical materials as well. We recommend supplying school officials with these resources in conjunction with consultations about what will be needed from these officials to help resolve the case. Examples are provided here (Bye, Alvarez, & Haynes, 2010; Kearney, 2008a; Kearney & Bates, 2005; Kearney & Bensaheb, 2006; Reid, 2000; Thambirajah, Grandison, & De-Hayes, 2008; Wimmer, 2003).

Final Comments

Cases of school refusal behavior are quite challenging for clinicians given their urgent, complex, and vital nature. Clinicians are encouraged to set into motion a series of generic recommendations presented here prior to more formal treatment that is tailored more carefully to a given case. In addition, clinicians are encouraged to assemble and consult with a team of persons (school-based personnel, parents, family social support network) to reduce the burden of treatment and to set boundaries regarding consultation time. The suggestions provided here can hopefully ease the sense of apprehension that arises when a client asks "What now?"

References

- Bernstein, G.A., Borchardt, C.M., Perwein, A.R., Crosby, R.D., Kushner, M.G., Thuras, P.D., & Last, C.G. (2000). Imipramine plus cognitive-behavioral therapy in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 39*, 276-283.
- Bernstein, G.A., Massie, E.D., Thuras, P.D., Perween, A.R., Borchardt, C.M., & Crosby, R.D. (1997). Somatic symptoms in anxious-depressed school refusers. *Journal of the American Academy of Child and Adolescent Psychiatry, 36*, 661-668.
- Bye, L., Alvarez, M.E., Haynes, J., & Sweigart, C.E. (2010). *Truancy prevention and intervention: A practical guide*. New York: Oxford.
- Carroll, H.C.M. (2010). The effect of pupil absenteeism on literacy and numeracy in the primary school. *School Psychology International, 31*, 115-130.
- Csoti, M. (2003). *School phobia, panic attacks and anxiety in children*. London: Jessica Kingsley.
- Egger, H.L., Costello, E.J., & Angold, A. (2003). School refusal and psychiatric disorders: A community study. *Journal of the American Academy of Child and Adolescent Psychiatry, 42*, 797-807.
- Eisen, A.R., & Engler, L.B. (2006). *Helping your child overcome separation anxiety or school refusal: A step-by-step guide for parents*. Oakland, CA: New Harbinger.
- Henry, K.L. (2007). Who's skipping school: Characteristics of truants in 8th and 10th grade. *Journal of School Health, 77*, 29-35.
- Henry, K.L., & Huizinga, D.H. (2007). Truancy's effect on the onset of drug use among urban adolescents placed at risk. *Journal of Adolescent Health, 40*, 358.e9-358.e17.
- Heyne, D., & Rollings, S. (2002). *School refusal*. Malden, MA: BPS Blackwell.
- Heyne, D., King, N.J., Tonge, B.J., & Cooper, H. (2001). School refusal: Epidemiology and management. *Paediatric Drugs, 3*, 719-732.
- Heyne, D., King, N.J., Tonge, B.J., Rollings, S., Young, D., Pritchard, M., & Ollendick, T.H. (2002). Evaluation of child therapy and caregiver training in the treatment of school refusal. *Journal of the American Academy of Child and Adolescent Psychiatry, 41*, 687-695.
- Kearney, C.A. (2001). *School refusal behavior in youth: A functional approach to assessment and treatment*. Washington, DC: American Psychological Association.
- Kearney, C.A. (2007a). Forms and functions of school refusal behavior in youth: An empirical analysis of absenteeism severity. *Journal of Child Psychology and Psychiatry, 48*, 53-61.
- Kearney, C.A. (2007b). *Getting your child to say "yes" to school: A guide for parents of youth with school refusal behavior*. New York: Oxford.
- Kearney, C.A. (2008a). An interdisciplinary model of school absenteeism in youth to inform professional practice and public policy. *Educational Psychology Review, 20*, 257-282.
- Kearney, C.A. (2008b). School absenteeism and school refusal behavior in youth: A contemporary review. *Clinical Psychology Review, 28*, 451-471.
- Kearney, C.A., & Albano, A.M. (2004). The functional profiles of school refusal behavior: Diagnostic aspects. *Behavior Modification, 28*, 147-161.
- Kearney, C.A., & Albano, A.M. (2007a). *When children refuse school: A cognitive-behavioral therapy approach/Therapist guide*. New York: Oxford.
- Kearney, C.A., & Albano, A.M. (2007b). *When children refuse school: A cognitive-behavioral therapy approach/Parent workbook*. New York: Oxford.
- Kearney, C.A., & Bates, M. (2005). Addressing school refusal behavior: Suggestions for frontline professionals. *Children and Schools, 27*, 207-216.
- Kearney, C.A., & Bensaheb, A. (2006). School absenteeism and school refusal behavior: A review and suggestions for school-based health professionals. *Journal of School Health, 76*, 3-7.
- Kearney, C.A., & Silverman, W.K. (1996). The evolution and reconciliation of taxonomic strategies for school refusal behavior. *Clinical Psychology: Science and Practice, 3*, 339-354.
- Kearney, C.A., & Silverman, W.K. (1999). Functionally-based prescriptive and nonprescriptive treatment for children and adolescents with school refusal behavior. *Behavior Therapy, 30*, 673-695.
- King, N.J., & Bernstein, G.A. (2001). School refusal in children and adolescents: A review of the past 10 years. *Journal of the American Academy of Child and Adolescent Psychiatry, 40*, 197-205.

- King, N.J., Tonge, B.J., Heyne, D., Pritchard, M., Rollings, S., Young, D., Myerson, N., & Ollendick, T.H. (1998). Cognitive-behavioral treatment of school-refusing children: A controlled evaluation. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 395-403.
- Last, C.G., Hansen, C., & Franco, N. (1998). Cognitive-behavioral treatment of school phobia. *Journal of the American Academy of Child and Adolescent Psychiatry, 37*, 404-411.
- McShane, G., Walter, G., & Rey, J.M. (2001). Characteristics of adolescents with school refusal. *Australian and New Zealand Journal of Psychiatry, 35*, 822-826.
- Pina, A.A., Zerr, A.A., Gonzales, N.A., & Ortiz, C.D. (2009). Psychosocial interventions for school refusal behavior in children and adolescents. *Child Development Perspectives, 3*, 11-20.
- Reid, K. (2000). *Tackling truancy in schools: A practical manual for primary and secondary schools*. London: Routledge.
- Thambirajah, M.S., Grandison, K.J., & De-Hayes, L. (2008). *Understanding school refusal: A handbook for professionals in education, health and social care*. Philadelphia, PA: Kingsley.
- Wimmer, M.B. (2003). *School refusal: Assessment and intervention within school settings*. Bethesda, MD: National Association of School Psychologists.
- Yahaya, A., Ramli, J., Hashim, S., Ibrahim, M.A., Kadir, H.B.H., Boon, Y., & Rahman, R.R.R. (2010). The effects of various modes of absenteeism problem in school on the academic performance of students in secondary schools. *European Journal of Social Sciences, 12*, 624-639.