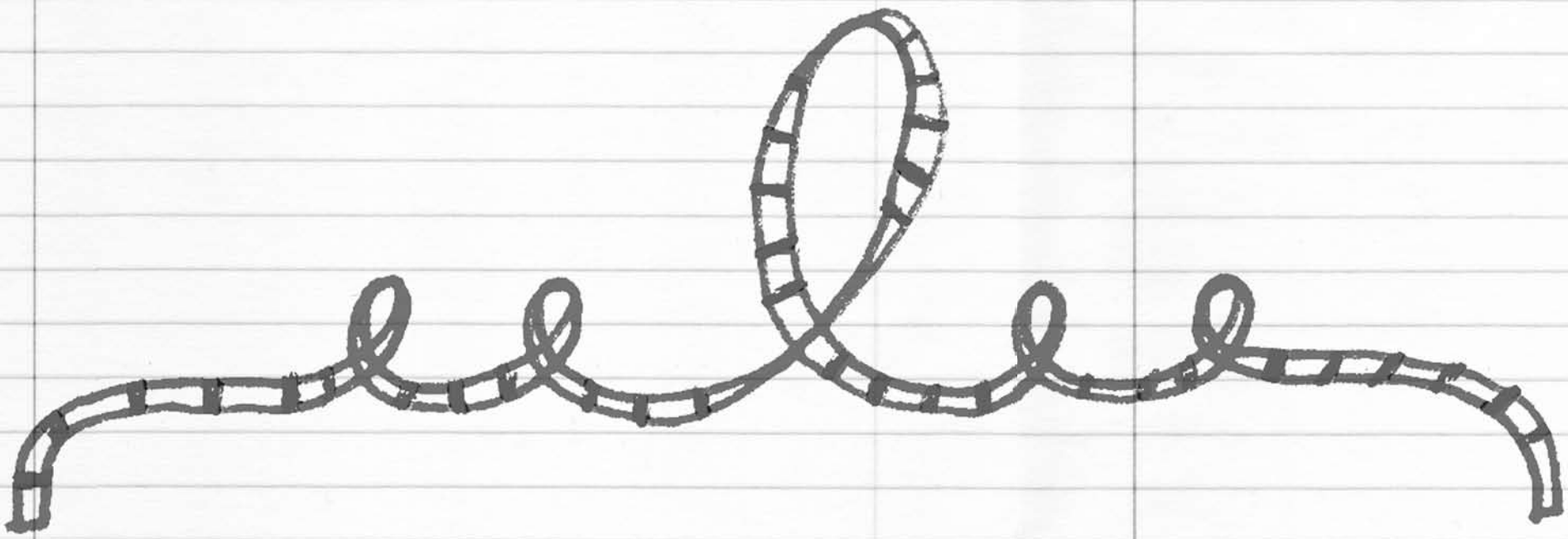
The @school project : developmental considerations in the design and delivery of cognitive-behavioural therapy for adolescent school refusal

Sauter, F.M.

Chapter 1

General Introduction



Anxiety-based school refusal[1] is an attendance problem characterized by a young person's difficulty in going to school, accompanied by emotional distress on the part of the young person and parental attempts to return the young person to regular school attendance.

> "...It all started when I was going from my Second Year...in High School to my Third Year. We have to pick subjects for our GCSE's [tertiary entrance exams] and so when I had a meeting with my Guidance teacher, he told me Third Year was going to be brilliant for me...The reality was different. I had serious trouble with my German teacher and so asked to be moved class...but they refused bluntly. Over this period of time I decided to just go to the school library during German classes...Nothing was said, apart from I was told I was breaking the law by doing so...Then I started becoming scared of school. I would have panic attacks on the way...I couldn't concentrate on anything...Then I started getting picked on...After a while, I was feeling really low and so...I told my mum I wasn't going anymore. She phoned the school constantly and got meetings but it was too late. I felt like nothing would help me be there. I felt allergic to the building...I love learning and I'm a good student but I can't be at school and moving school doesn't seem like a very good option. I'm scared I'll make a mess of my life but I see no other way out..."
> Rosie, aged 15 (Scared of school, 2005)

Persistent school refusal poses a significant threat to a young person's social, emotional, and academic development and can jeopardize longer-term occupational functioning and mental health (Flakierska-Praquin, Lindström, & Gillberg, 1997; Heyne, King, Tonge, & Cooper, 2001). In addition, successful management of school refusal often presents a challenge to parents, school staff, and mental health professionals (Heyne & King, 2004). Young people with school refusal frequently meet diagnostic criteria for internalizing psychological disorders (Egger, Costello, & Angold, 2003; Hersov, 1985). As such, cognitive and behavioural techniques used in treating internalizing disorders, such as the restructuring of cognitions and systematic desensitization, are often incorporated in treatments for school refusal (Heyne & Rollings, 2002; Kearney, 2003). Cognitive-behavioural therapy (CBT) is considered an efficacious intervention for school refusal in young people, with encouraging empirical evidence to support its application (e.g., Heyne et al., 2002; King et al., 1998). CBT for school refusal is aimed at promoting regular and voluntary attendance and relieving emotional symptoms such as anxiety and depression. Individual and parent sessions, as well as consultation with schools, are seen as important parts of the treatment.

In adolescence, school refusal is particularly prevalent, complex, and treatment-resistant (Heyne, 1999; Last, Hansen, & Franco, 1998). Indeed, school refusal appears to be more common among adolescents relative to children (e.g.,

[1] Hereafter known as school refusal.

Kearney, Eisen, & Silverman, 1995; Last, 1992). In terms of severity, greater levels of absenteeism have been reported for school-refusing adolescents than for school-refusing children (Hansen, Sanders, Massaro, & Last, 1998). Given that adolescents with anxiety are often diagnosed with several concurrent anxiety disorders, as well as depression (Ollendick, Jarrett, Grills-Taquechel, Hovey, & Wolff, 2008), adolescent school refusers may exhibit high levels of comorbidity. These factors may be related to inferior treatment response in adolescent school refusers. Several studies have reported that school-refusing adolescents improve to a lesser extent following treatment, relative to younger children (Heyne, 1999; Last et al., 1998). Furthermore, the adolescent period is associated with a broad range of intrapersonal (e.g., cognitive development), interpersonal (e.g., autonomy strivings in the family context), and environmental changes (e.g., approaching school-leaving age) which have the potential to effect the therapeutic process and the outcomes of treatment (Holmbeck, O'Mahar, Abad, Colder, & Updegrove, 2006).

An awareness of biological, social-emotional, psychosocial, and cognitive factors specific to adolescence is therefore essential when working with school-refusing adolescents. By conducting 'developmentally-appropriate CBT', or cognitive-behavioural interventions which take into account the developmental level of an individual client, clinicians can increase their chances of successfully engaging young people in treatment (Holmbeck et al., 2006). Indeed, developmentally-appropriate treatments for anxious adolescents are beginning to emerge (e.g., Kendall, Choudhury, Hudson, & Webb, 2002; Siqueland, Rynn, & Diamond, 2005). While several treatment outcome studies utilizing CBT for school refusal have been published (e.g., Heyne et al., 2002; King et al., 1998), the efficacy of a developmentally-appropriate approach with adolescent school refusers has not yet been investigated.

Therefore, the major aims of the current research were: (i) to prepare for a open trial of a developmentally-appropriate CBT for adolescent school refusal by developing a modularized treatment manual, and developing measures which allowed for the examination of developmental predictors of treatment outcome; (ii) to implement this CBT and determine, by means of the open trial, whether the CBT for adolescent school refusal was associated with improvements in attendance, emotional symptoms, and self-efficacy, and was acceptable for young people, parents, school staff, and clinicians; and (iii) to explore whether the outcomes of the CBT for adolescent school refusal were influenced by developmental factors such as the adolescents' cognitive capacities and autonomy development, and the clinicians' developmentally-appropriate delivery of the treatment. Below, an overview of the characteristics, prevalence, and management of various types of school attendance problems is provided, focusing in particular on school refusal in adolescence[2].

[2] Elements of this chapter have appeared previously in Sauter (2004). For a recent and complete review of a range of issues related to school refusal, see Heyne (2006).

Following this overview, the hypotheses of the current research and an outline of this dissertation are presented.

School attendance problems

Going to school is a fact of life for most children and adolescents in westernized countries where school attendance is compulsory. Young people spend a large part of the day at school and it is the place where most of their academic, social, and personal interactions take place (Patton, Bond, Butler, & Glover, 2003). Additionally, schools are important societal institutions for the education of young people, for the stimulation of positive outcomes, and for the prevention of problem behaviours (Felner et al., 2001; Greenberg et al., 2003). For many families, the biggest dilemmas faced in the morning are deciding which clothes to wear and what to pack in the daily lunch box. In some households, however, school attendance can be a source of upset, conflict, and crisis for all concerned. Given the substantial consequences of non-attendance for young people, effective identification and management of school attendance problems is of essential importance.

Distinguishing between problematic versus non-problematic absence

An important issue in the accurate identification of school attendance problems is the distinction between 'non-problematic' and 'problematic' absenteeism. Frequently, signalling of problematic absenteeism is focused on the rate of non-attendance, as well as whether the absence from school is legitimate (i.e., with reasons agreed upon by school and parents, such as illness, funerals, and religious holidays). Problematic absenteeism therefore excludes legitimate and temporary absences due to infrequently occurring events that can be compensated for at a later date (i.e., with extra class work). Kearney (2003) suggested the following criteria for determining problematic absenteeism: (a) if a school-age youth has missed most (> 50%) of school time for at least two weeks; or (b) if a disturbance in the young person's or family's daily routine for a period of at least two weeks is caused by the difficulties associated with going to school. Other studies have reported attendance rates of between 15 and 25 percent as being problematic (e.g., Bernstein et al., 2000; Galloway, 1985) In Heyne and colleagues' (2002) treatment outcome study, a rate of 90 percent attendance (calculated by tallying the number of half days the young person was present in the two weeks prior to the assessment) was reported as a 'successful' outcome. Attendance of less than 90 percent attendance was regarded as 'non-successful'.

In distinguishing between 'problematic' and 'non-problematic' attendance, the Law on Compulsory Education [Leerplichtwet] in The Netherlands makes an initial distinction between 'disallowed' and 'allowed' absences. The latter refers to absences due to illness or special circumstances such as funerals or religious occasions. In addition, the rate of non-attendance is also taken into account: a pupil may have up to 10 'allowed absences' (with permission) a year. Disallowed absences

(or all absences without permission) of more than three continuous days or 1/8th of lesson time in four weeks must be reported to the local education welfare service [Regionaal Bureau Leerplicht] (Overheid.nl, 2009).

Despite these legally defined criteria, many schools and educational institutions in the Netherlands often determine and apply their own criteria for what level of absenteeism is regarded as problematic (Bos, Ruijters, & Visscher, 1992). Further, school attendance records are not uniformly kept across Dutch schools (Steketee, Mak, & Tierolf, 2009). When and how school staff take action in cases of disallowed absenteeism (e.g., contacting education welfare services) often depends on the individual schools' policy and regulations (Regionaal Bureau Leerplicht – Zuid-Holland Noord [RBL], 2003). Many school staff fail to report absenteeism in the early stages and only contact education welfare services if the absenteeism is chronic (RBL, 2003). A negative consequence of this practice is that the attendance problem may become increasingly difficult to treat. Research has suggested that the longer young people are absent from school, the more likely it is that they will consider themselves unable to cope with various aspects of school, and the more difficult it is to get them to resume regular attendance (Okuyama, Ikada, Kuribayashi, & Kaneko, 1999; Valles & Oddy, 1984).

Prevalence of problematic versus non-problematic absence

Reported rates of school non-attendance (both problematic and non-problematic) vary within the literature. Estimated international rates of non-attendance range from 9 to 20 percent of young people absent from school at any given time, depending on the definition of absenteeism used (Kearney, 2001). Higher rates of non-attendance are often reported for high school students relative to primary school students. Epstein and Sheldon (2002) reported an average daily absenteeism rate of seven percent in 12 American high schools. Similarly, Bos and colleagues (1992) reported a rate of absenteeism of 9.1 percent in a sample of 36 high schools in The Netherlands. A survey by the Dutch Institute for Public Opinion and Market Research found an average non-attendance rate in Dutch high schools of 7.9 percent (Nederlandse Instituut voor de Publieke Opinie en het Marktonderzoek [TNS-NIPO], 2002).

Data on the prevalence of problematic non-attendance is scarce. A recent Dutch study reported that 5.5 percent of 345 primary school students surveyed were absent from school without a valid reason (Vuijk, Heyne, & Van Efferen, 2010). Research into school absenteeism in the first four years of high school in The Netherlands indicated that the national average of unexplained and therefore presumably 'disallowed' absenteeism at any time was 2.9 percent (TNS-NIPO, 2002). In a more recent survey, the total rate of problematic absenteeism for the school year 2003-2004 as estimated by school staff from 14 Dutch high schools, was found to be 12 percent (Sauter, 2004).

Differentiation amongst types of problematic absenteeism

Differentiating between the different types of problematic absenteeism is an important consideration for the successful management of school attendance problems. While some scholars do not support the differentiation between types of school attendance problems (e.g., Lauchlan, 2003; Lyon & Colter, 2007), research suggests that different types of attendance problems may have different developmental pathways and aetiologies (Berg, 2002; Kearney, 2001), and may therefore require different approaches to management (Paccione-Dyszlewski & Contessa-Kislus, 1987; Stickney & Miltenberger, 1998). In the Dutch language, the expressions 'schoolweigering' [school refusal], 'ongeoorloofd schoolverzuim' [disallowed school absenteeism], 'spijbelen' [truancy], 'school fobie' [school phobia], and 'school ziekte' [school sickness] are often used interchangeably when referring to the unexplained and problematic absence of a young person from school. Similarly, terms such as school phobia, separation anxiety, school avoidance, psychoneurotic truancy, school reluctance, and truancy have all been used to describe problematic absenteeism (Heyne, 2006). Inconsistent labelling of school attendance problems may result in confusing and even erroneous information being accumulated about different types of problematic absenteeism (Heyne & King, 2004; Kearney, 2003; Stickney & Miltenberger, 1998).

A functional model of school attendance problems developed by Kearney and colleagues (Kearney, 2002; Kearney & Albano, 2004; Kearney, Lemos, & Silverman, 2006; Kearney & Silverman, 1996) allows for distinctions to be made between types of problematic absenteeism. The model identifies four functions served by a young person's refusal to attend school: (a) avoidance of the experience of anxiety or fearfulness related to attending school; (b) avoidance of social situations that are feared or which cause anxiety; (c) attention-seeking or bringing about a reduction in the feeling of separation anxiety; and (d) enjoyment of rewarding experiences that school non-attendance may bring. Kearney also developed a tool to assess these four functions of problematic absenteeism: the School Refusal Assessment Scale (SRAS; Kearney, 1993) and its revision (SRAS-R; Kearney, 2002). The SRAS-R aims to identify the functions of the young person's absence from school, so that prescribed treatments can be assigned.

Although the SRAS-R and its associated functional profiles provide a useful framework for conceptualizing and addressing non-attendance, another approach to distinguishing between different types of problematic school absenteeism is often applied. Types of problematic absenteeism can also be differentiated based on their aetiology, phenomenology, and contributing factors, rather than based solely on the function that the behaviour serves for the individual. This approach yields three categories of school attendance problems: truancy, school refusal, and school withdrawal (Berg, 2002; Elliot, 1999; Heyne et al., 2001; Lauchlan, 2003)[3]. Following a brief discussion of truancy and school withdrawal, the characteristics, prevalence, and treatment of school refusal will be further examined.

Truancy

Child-motivated absenteeism involves a young person's refusal to attend school and/or their difficulty with remaining in classes for an entire day (Kearney & Silverman, 1990. Truancy refers to child-motivated absence which is characterized by unlawful school non-attendance without the knowledge and consent of the parent(s). Attempts are made by the young person to conceal the non-attendance from parents and school staff (Kearney, 2003). Barth's (1986) description of 16-year-old Judy illustrates some of the features of truancy:

> "...she rarely attends school for a whole day or on a Monday or Friday. Instead, she prefers to drink with her boyfriend or frequent the shopping malls with friends...Judy surely enjoys the pleasures of non-attendance... [she]...gets few rewards from attending class and lacks self-management strategies for dealing with the many frustrations of school."
> (Barth, 1986, p. 225)

Previous research has demonstrated a relationship between truancy and academic underachievement, as well as psychopathology such as conduct disorders and hyperactivity disorders (cf. Berg, 2002). Studies into rates of absence due to truancy report that approximately three to four percent of students truant on any given day, depending on the definition of truancy used and the time of the school year (Berg, 1992; Bos et al., 1992). Truancy-related absenteeism has been reported to be less common in primary schools than in high schools (Galloway, 1982, 1985). Case reports in the literature have indicated that several strategies administered by parents or school staff are useful in addressing truancy-based school absenteeism, including close supervision and surveillance of students, behaviour contracts, contingency management, and rewards for good behaviour (Bell, Rosen, & Dynlacht, 1994; Berg, 1985; Berg, 2002; Epstein & Sheldon, 2002; Kearney & Silverman, 1999; MacDonald, Gallimore, & MacDonald, 1970; Noonan & Thibeault, 1974). Treatment approaches for truancy can also involve consultation with external community agencies (Hanson & Hoeft, 1982; Mattison, 2002; Murphy & Wolkind, 1996). For example, educational welfare officers (i.e., akin to the Dutch 'leerplichtambtenaar') can make home visits and are involved in the judicial procedures that can be a result of truancy (Berg, 1985; Wright & Wardle, 1996).

[3] The existence of a mixed type of absenteeism, whereby young people display a combination of school refusal and truancy characteristics, as well as features of school withdrawal, has been reported in previous studies, though rarely in clinical situations (Bools, Foster, Brown, & Berg, 1990). It will therefore not be further investigated in the present research.

School withdrawal

According to Kearney (2003), parent-motivated absenteeism is considered problematic when the school does not accept the reasons given by the parent for the young person's absence. School withdrawal is parent-motivated absenteeism, in that it is associated with parental or caregiver ambivalence or opposition to the young person attending school regularly (Kahn & Nursten, 1962). For example, sickness can be used as an excuse for the non-attendance while the young person actually stays at home to look after or provide company for family member(s), or works outside the home during school hours (Teasley, 2004). The following vignette illustrates this type of problematic absenteeism:

> "Another possible reason for non-attendance…is the pupil staying at home to look after their sick parent. Related to this may be that the pupil's parents are not fit or competent enough to organize their child in the mornings to get ready for school." (Lauchlan, 2003, p. 136)

Due to the lack of research into school withdrawal, there is relatively little known about the aetiology, prevalence, and treatment of this type of school attendance problem. Research in Great Britain by Galloway (1985) found that between 1974 and 1976, 11 to 15 percent of young people aged 5 to 11 years, and 13 to 17 percent of young people aged 12 to 16 years were persistently absent from school with their parents' knowledge, consent and approval (analogous to school withdrawal). Absences with parental knowledge and consent were almost equally common in primary and high schools (59% and 51% respectively; Galloway, 1982, 1985). Strategies drawn from research into parental involvement in schooling may inform approaches to managing school withdrawal. Research has shown that parent monitoring of attendance and parental contributions to the education of their child are significantly associated with decreased absenteeism (Anderson, Christenson, Sinclair, & Lehr, 2004; Astone & McLanahan, 1991; McNeal, 1999). Alternatively, school staff may choose to refer families of young people not attending due to school withdrawal to external agencies such as social services or social work to acquire financial and mental health assistance (Barth, 1986; Berg, 2002; Teasley, 2004).

School refusal

School refusal involves a young person's difficulty in going to school, together with emotional disturbance on the part of the young person and parental attempts to get the young person to go to school (Heyne & King, 2004). School refusal can be gradual or sudden in onset, and certain triggers may be related to its occurrence, such as stressful events at school or in the family (Berg, 2002; Egger et al., 2003; Heyne et al., 2002). Berg and colleagues (Berg, 2002; Berg et al., 1985) developed a number of criteria to define school refusal, based on research into attendance problems. These criteria include: (a) reluctance or refusal to attend school often leading to prolonged

absence; (b) the young person usually remaining at home during school hours rather than concealing the problem from parents; (c) displays of emotional upset at the prospect of attending school (e.g., somatic complaints, anxiety); (d) an absence of severe antisocial behaviour beyond resistance to attempts to get them to go to school; and (e) reasonable parental efforts to secure the young person's attendance at school. The following vignette characterizes some of the features of school refusal:

> "…Nick complained of headache and nausea…At that time…his mother… expressed extreme frustration at not being able to coax Nick into returning to school…he remained indoors the entire time, [and] left the house only when accompanied by a parent…" (Paccione-Dyszlewksi & Contessa-Kislus, 1987, p. 379)

Bools and colleagues (1990) found that half of their sample of school-refusing young people displayed symptoms of anxiety and/or depression. Similarly, Buitelaar, Van Andel, Duyx, and Van Strien (1994) found that an anxiety disorder was the most common diagnosis in a sample of 25 day-patient adolescents with school refusal. In their study of school attendance problems in a community sample, Berg and colleagues (1993) found that approximately one-fifth of the non-attending young people sampled met the criteria for an anxiety or mood disorder (including overanxious and generalized anxiety disorder, phobias, and depression) according to the DSM-III-R (American Psychiatric Association, 1980).

A key characteristic of school refusal is that it is marked by heterogeneity in its presentation (Heyne, 2006). For example, some school-refusing young people are absent for several months, others attend school irregularly, and yet again others attend school but consistently arrive late. In samples of school-refusing young people, a wide range of anxiety disorders are found to be present, including social anxiety, separation anxiety, generalized anxiety, and anxiety disorder not otherwise specified. School refusal is also associated with mood disorders such as depression (Bools et al., 1990; Buitelaar et al., 1994; Flakierska-Praquin et al., 1997), especially in adolescence (Baker & Wills, 1978). Young people with school refusal often have problems with social contacts (e.g., being bullied, difficulty in making friends; Buitelaar et al., 1994; Egger et al., 2003). Family factors such as parental stress, parental psychopathology, marital tension, and family conflict have also been linked to the development and maintenance of school refusal (Heyne, 2006).

In international research into the prevalence of school refusal, rates between 0.1 to 25 percent have been cited, depending on factors such as the population studied and the criteria used to define school refusal (Fremont, 2003; Heyne & King, 2004). Previous studies have reported equal rates of school refusal-related non-attendance in both primary and high school students (e.g., Galloway, 1982, 1985). In the Netherlands, Vuijk et al. (2010) reported a prevalence of 2.0 percent in their sample of Dutch primary school aged children. A lower prevalence was reported by

the staff of 14 Dutch high schools in the Duin and Bollenstreek region (0.6% of all cases of problematic absenteeism; Sauter, 2004). In clinically-referred samples, the prevalence of school refusal varies between five percent and 16 percent, with higher rates often found in adolescent populations (Burke & Silverman, 1987; McShane, Walter, & Rey, 2001).

Effects of absence from school due to school refusal

School refusal impacts negatively on young people, their parents, and school staff. Short-term consequences of school refusal for the young person include academic underachievement, social isolation, and problems with peer relationships (Hersov, 1972; Heyne et al., 2001). Long-term consequences of school refusal can include employment difficulties, antisocial behaviour, and a higher rate of psychiatric illnesses such as depression and anxiety in adulthood (Berg & Jackson, 1985; Bools et al., 1990). In a ten-year follow-up study by Berg (1970), adults who refused to attend school in childhood were found to experience adjustment problems in the home and work environments, as well as problematic relationships with peers. Extra expenses due to lost work time, as well as the daily battle in getting the young person to go to school can all result in tensions within the family (Barth, 1986). In the long term, the high levels of stress experienced by the parents of school-refusing young people may add to marital distress and parental anxiety and depression (Heyne & King, 2004; Kearney & Hugelshofer, 2000). The detection and management of school refusal similarly costs school psychologists, counsellors, and administrators much time and resources. Directly, a young person's refusal to go to school can result in disruptions in the class for the teacher and other school staff involved. For example, teachers must invest considerable time in helping a school-refusing young person catch up and then keep up with class work. Indirectly, persistent absenteeism violates the norms which school staff strive to uphold: the importance of being at school for social and academic learning (Barth, 1986).

Treatment of school refusal

While several studies have also investigated the efficacy of pharmacological interventions for cases of school refusal (e.g., Bernstein et al., 2000; Bernstein, Hektner, Borchardt, & McMillan, 2001), the most commonly evaluated intervention for school refusal is cognitive-behavioural therapy (CBT). Given the overlap in clinical presentation and causal factors between anxiety and school refusal (Egger et al., 2003), cognitive therapeutic techniques and behavioural therapeutic techniques for managing anxiety are incorporated in programs to treat school-refusing young people. A number of studies attest to the efficacy of CBT in reducing internalizing problems and promoting school attendance (Heyne et al., 2002; King et al., 1998; Last et al., 1998). For example, in a study by King et al. (1998), thirty-four school-refusing young people aged 5 to 15 years were randomly assigned to six sessions of individual

CBT plus parent/teacher training (5 sessions with parents/1 meeting with school) or a waiting-list control condition. The individual CBT involved both behavioural therapeutic strategies (e.g., training in relaxation, exposure, and social skills training) and cognitive therapeutic strategies (e.g., modifying maladaptive cognitions). Parent and teacher training included preliminary considerations such as school placement, behaviour management strategies (e.g., planned ignoring and rewards), and the development of an attendance plan. Results indicated that the young people treated with CBT improved to a greater extent in terms of school attendance, self-reported fear, anxiety, depression, and self-efficacy relative to those children and adolescents in the waiting-list condition.

King and colleagues (1998) suggested that the successful results following the brief, intensive treatment may have been due to high caregiver involvement in the intervention. However, they also recommended future studies examine the relative contributions of individual CBT and parent/teacher training. Accordingly, Heyne et al. (2002) evaluated the comparative efficacy of individual CBT, parent and teacher training, and combined individual CBT/parent and teacher training in the treatment of school refusal. Sixty-one young people from 7 to 14 years of age were randomly assigned to the three different treatment conditions. Results indicated that there were significant improvements over time across all three treatment conditions. At post-treatment, both conditions which involved parents and teachers led to fewer internalizing problems as reported by mothers relative to the individual CBT condition (Heyne et al., 2002). No significant differences in outcomes were found between the conditions at four-month follow-up.

The results of the aforementioned studies indicate that there is a substantial base of evidence for the efficacy of CBT for school refusal (King, Heyne, & Ollendick, 2005). However, the intervention does not yet meet criteria for designation as a 'well-established treatment' (King, Tonge, Heyne, & Ollendick, 2000; Silverman, Pina, & Viswesvaran, 2008). In their study of 56 school-refusing children and adolescents, Last and colleagues (1998) reported that an attention-control placebo was equally effective as CBT in improving attendance rates and reducing anxious symptoms. Further, a series of studies into the effectiveness of CBT with anxious-depressed adolescent school refusers found that CBT was not effective unless combined with imipramine (Bernstein et al., 2000, 2001).

Research into the predictors of treatment outcome of CBT for school refusal may allow for improvements in treatment response. Knowledge of the factors leading to treatment response or non-response can allow for tailoring of interventions to specific individuals, which in turn may enhance treatment efficacy (March & Curry, 1998). Although few studies have investigated predictors of outcome of CBT for school refusal, Layne, Bernstein, Egan, and Kushner (2003) reported that the severity of school attendance problems, the diagnostic profile, and the type of treatment administered can all impact upon the efficacy of CBT for school refusal with adolescents.

School refusal in adolescence: Prevalence, presentation, and treatment

Developmental factors may also influence the treatment outcomes of school-refusing adolescents. Adolescence is a unique developmental phase in terms of the onset and presentation of school refusal (Heyne, 2006). There are major peaks in the incidence of school refusal during adolescence, corresponding with transitions between primary school and junior high school, and between junior high school and high school (McShane et al., 2001; Ollendick & Mayer, 1984). Indeed, school refusal appears to be more common among adolescents relative to children (e.g., Berg, 1992; Kearney et al., 1995; Last, 1992). Studies into school refusal have often included a large percentage of young people aged 12 years or older (e.g., 47.1% in King et al., 1998; 65.6% in Heyne et al., 2002).

In terms of the presentation of school refusal, Baker & Wills (1978) reported that acute school phobia (i.e., the onset of school phobia following three years of trouble-free attendance at school; school phobia being equivalent to school refusal) was most common in adolescents relative to children. Hersov (1985) suggested that older school refusers are more likely to display an insidious onset than younger school refusers. Adolescents with anxiety disorders are often diagnosed with additional anxiety disorders and with mood disorders (Ollendick et al., 2008); therefore, school-refusing adolescents may display greater diagnostic comorbidity than younger school refusers. In older children and adolescents with school refusal, common disorders are social phobia, panic disorder, and depressive disorders. Separation anxiety disorder is more common in younger school refusers relative to school-refusing adolescents (Baker & Wills, 1978; Last & Strauss, 1990). Berg & Collins (1974) also suggested that the emotional upset displayed by school phobic adolescents faced with attending school may often present as anger and defiance, rather than fear and sadness.

Adolescents also appear to be less responsive to currently available versions of CBT for school refusal, relative to younger children. Last and colleagues (1998) found that adolescents were less likely than younger children to achieve 95 percent attendance by post-treatment following individual CBT. Heyne (1999) also found that adolescent school refusers (aged 12-14 years) had attained significantly lower levels of school attendance at follow-up than children (aged 7-11 years). Several factors may account for this poorer treatment response. School refusal during the adolescent years appears to be more severe than in childhood, with greater levels of absenteeism being reported among school-refusing adolescents (Hansen et al., 1998). Indeed, the adolescent school refusers in the study by Heyne et al. (2002) had lower levels of school attendance (*M* attendance at pre-treatment = 12%) in comparison to the school-refusing children (*M* attendance at pre-treatment = 31%; Heyne, 1999).

Further, the clinical presentation of adolescent school refusal may be more complex, and thus this age group can be harder to treat. Anxious-depressed adolescent school refusers may be especially challenging clients, in that young

people with comorbid anxiety and depression often present with greater symptom severity and respond less to treatment (Berman, Weems, Silverman, & Kurtines, 2000). The diagnoses commonly found in adolescents with school refusal may also be the disorders which are challenging to treat, such as social phobia (Bernstein et al., 2001). For example, school refusers with social phobia may have deficits in social skills or competencies. Continued social skills deficits may decrease the chance of experiencing 'successful' exposures to school-related situations, as other classmates may react negatively to the young person's inappropriate behaviours. The exposures may therefore be less effective in reducing anxiety for these young people (Spence, Donovan, & Brechman-Toussaint, 2000) and the potency of the treatment attenuated.

Developmental factors associated with adolescence can also influence the therapeutic process and in turn, the treatment outcomes of adolescent school refusers (Sauter, Heyne, & Westenberg, 2009). The adolescent phase is defined by transitions in *individual*, *family*, *social*, and *school* factors, and these changes, "…[can alter] one's developmental trajectory …in positive and negative directions" (Holmbeck et al., 2006, p. 422). Developmental changes can also facilitate or impede and adolescent's responsiveness to treatment and hence influence their treatment outcomes (Weisz & Hawley, 2002).

An *individual* developmental factor which is of particular significance to CBT is the influence of CBT-relevant cognitive capacities on engagement in treatment, and in particular in cognitive therapeutic techniques in CBT. Metacognitive capacities such as self-reflection and insight allow young people to engage in CBT-relevant activities, such as the identification of (the relationships between) thoughts, feelings, and behaviours (Suveg, Comer, Furr, & Kendall, 2006). While many of the cognitive capacities relevant to CBT are acquired during adolescence, not *all* adolescents develop cognitive capacities to the same extent. Some adolescents may therefore be less able to successfully engage in *all* cognitive therapeutic techniques (Oetzel & Scherer, 2003).

Adolescent autonomy development in the *family* context can also impact the process and outcomes of treatment (Stallard, 2002b). The separation-individuation process in the parent-child relationship is seen to be related to separation anxiety-based school refusal in younger children (Elliot, 1999). The same process is also implicated in school refusal in adolescence, but in a more complex form. In the adolescent period, the achievement of a secure and lasting separation from the parents and the development a sense of self is of utmost importance. Adolescents who have difficulties in negotiating these developmental tasks may be susceptible to developing school refusal (Goldberg, 1977; Jackson, 1964; Rubenstein & Hastings, 1980). Indeed, Berg & Collins (1974) linked adolescent wilfulness, stubbornness, and assertiveness in the family situation to the occurrence of school refusal in the adolescent period. Similarly, Jackson (1964) described the school refusal of four

adolescent clients as "...an open attempt to assert themselves as persons in their own right, to stand up to their parents and parent-figures such as teachers..." (p. 72). Due to an interaction between anxiety-motivated avoidance and defiance fuelled by strivings for autonomy, adolescents with school refusal may be more likely, and more (physically) able, to resist parents' and teachers' efforts to return them to regular school attendance (Hansen et al., 1998). Adolescent school refusers may demand to decide themselves 'when and how' they return to school. Planning for school return can thus become a source of conflict and tension between adolescents and parents, and a source of ambivalence towards a clinician who places the issue of school attendance on the therapeutic agenda.

Changes in the *social* context of adolescents may also impact the treatment of school refusal. Improvements in social perspective-taking ability may prompt school-refusing adolescents to increasingly evaluate what others 'think of them' (Albano, 1995). At school, many anxious adolescents feel that their behaviour, appearance, and social skills are under constant scrutiny by their peers (Albano, 1995). At the same time, social acceptance by peers is especially important during adolescence (Geldard & Geldard, 2004). School-refusing young people may have problems 'fitting in' with their classmates, due to their long absences, and deficits in social skills resulting from infrequent interactions with peers (Taylor & Adelman, 1990). Place, Hulsmeier, Davis, and Taylor (2000) stated that many of the adolescent school refusers in their study reported negative social experiences at school such as bullying or teasing, and feelings of loneliness and vulnerability. Taken together, school-refusing adolescents' greater self-awareness and the increased importance of peers may heighten their anxiety related to school attendance. Further, social factors may impact on the process of treatment with school-refusing adolescents. For example, in-session exposure practice may not adequately prepare the adolescent to deal with unanticipated occurrences within in-vivo exposures at school (i.e., peers reacting to the adolescent in an unexpected way). The adolescent may then be less motivated to re-attempt a 'failed' exposure, delaying or disrupting plans for increasing school attendance.

In terms of developmental factors associated with the *school* context, the transition to high school impacts on the process of treatment of school refusal and hence treatment outcomes. Increasing academic and (school-related) social demands can contribute to high levels of stress for school-refusing adolescents (Heyne, 2006). In addition, due to the importance of school results for entrance to tertiary studies, high schools may be less willing to make special accommodations for catching up on missed classes or developing an adjusted class schedule. This may in turn delay or disrupt school attendance plans made in treatment. A receptive atmosphere at school is essential for a successful re-entry to school (Taylor & Adelman, 1990). However, high school staff members who function as a contact person for the school-refusing adolescent may have a high 'caseload' or may share the task with several other staff

members, making them less available as a source of support for the young person. In addition, communication amongst staff members about special entry plans may be poor, increasing the risk that well-prepared attendance plans are thwarted.

Summary and hypotheses of this dissertation

In order to accurately identify school attendance problems, it is important to distinguish between types of school attendance problems. A common differentiation is that made between truancy, school withdrawal, and school refusal. School-refusing young people are absent from school with parental knowledge but without their approval, and going to school is often accompanied by somatic complaints and anxiety. Due to the serious short-term and long-term consequences of prolonged absence from school for young people, their families and schools, effective strategies to treat school refusal are of key importance. Numerous treatment outcome studies point to the efficacy of CBT for school refusal. However, adolescent school refusers are a unique population due to the influence of developmental tasks and transitions on the prevalence, presentation, and treatment of school refusal. It is therefore important that adolescent developmental factors be considered when designing and delivering CBT. To enhance the efficacy of CBT for school-refusing adolescents, an existing practitioner guide for school-refusing children and adolescents (Heyne & Rollings, 2002) was extended and modified to take into account adolescent developmental factors. The preparation, implementation, and systematic evaluation of the resulting treatment - the '@school project' (Heyne, Sauter, & Van Hout, 2008) - was the objective of the current research and the topic of this dissertation.

No hypotheses were proposed in relation to the first aim of the current research, namely the preparation of an open trial of a developmentally-appropriate CBT for adolescent school refusal. The results of the preparatory process will be presented in this dissertation descriptively in Chapters 2 and 3. The hypotheses associated with the second aim, the implementation and systematic evaluation of the treatment, were: i) the treatment would be associated with an increase in school attendance, a decrease in anxious and depressive symptoms as reported by the adolescent and parents, and an increase in self-efficacy in both the adolescents and parents; and ii) the treatment would be perceived as being acceptable by adolescents, parents, school staff, and clinicians. If indeed improvements in functioning (with respect to school attendance, emotional symptoms, and self-efficacy) are evident at post-treatment and at follow up, and the developmentally-appropriate CBT intervention is found to be acceptable, this will provide preliminary support for the efficacy of this developmentally-appropriate treatment for the management of school refusal in adolescents. The association between developmental factors and the treatment outcomes of adolescent school refusers has not been examined in previous studies. Therefore, the third aim, the examination of the relative importance of developmental factors in the prediction of treatment outcome, was analysed exploratively. The identification of developmental

factors which are associated with positive treatment outcomes can facilitate the testing of these prediction relationships in subsequent randomized controlled trials. This information can further inform the tailoring of treatment for school-refusing adolescents in terms of their developmental needs and capacities.

Outline of this dissertation

The current dissertation encompasses a series of four studies. Following this General Introduction, Chapters 2 and 3 describe preparatory studies undertaken prior to the implementation of the open trial. In particular, Chapter 2 provides a theoretical rationale for the development of the '@school project' for school-refusing adolescents, by drawing on the developmental psychology, developmental psychopathology, and clinical child and adolescent psychology literature. Information relevant to CBT, anxiety, and adolescent development drawn from a wide range of sources was reviewed and synthesized in order to inform the development of a CBT for school refusal in adolescence. To enhance the generalizability and applicability of the review, and given the overlap in clinical presentation and aetiology between anxiety and school refusal, the scope was broadened to adolescent anxiety disorders. The chapter discusses 'why' it is important to consider developmental factors in designing and delivering CBT for anxious adolescents and 'how' clinicians can developmentally tailor CBT for anxious adolescents. The review identified six key domains of developmentally-appropriate treatment design and delivery which clinicians and researchers can be mindful of when working with anxious adolescents. Subsequently, Chapter 3 illustrates the development of a measure to assess developmental factors which have the potential to enhance the CBT outcomes in young people, namely CBT-relevant cognitive capacities. In this chapter, the translation, modification, and psychometric evaluation of the Self-Reflection and Insight Scale for Youth (SRIS-Y) with a Dutch community sample is described. Two smaller investigations are presented in this chapter: a pilot study, involving the translation and adaptation process and the results of item analyses, and a second study which explored the psychometric properties of the resulting measure.

Chapters 4 and 5 describe the implementation and systematic evaluation of the developmentally-appropriate treatment. In Chapter 4, this is in the form of a qualitative case study which allows for a more detailed description of the features of the treatment with the young person, parents, and school staff. The case study illustrates the application of the '@school project' with a 16-year-old female, her mother, and her homeroom teacher. Developmentally-appropriate treatment elements relevant to working with this challenging group of young people are highlighted. In Chapter 5, the treatment is evaluated in the form of an open trial whereby the statistical and clinical significance of the outcomes are tested. This chapter reports on both the efficacy and acceptability of the '@school project' for anxious school-refusing adolescents. The treatment outcomes of the participants at post-treatment and follow-up are

described. In addition, the associations between several developmental factors (e.g., cognitive capacities, autonomy, clinician developmental sensitivity), and treatment outcome are analysed exploratively. The dissertation concludes with a general discussion (Chapter 6) in which the main findings of the studies in this dissertation are re-stated and interpreted, the strengths and limitations of the studies explored, and suggestions for clinical practice and further research discussed.