

# Moving From Assessment To Treatment Of School Refusal Behavior In Youth

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School refusal behavior is a difficult problem faced by many parents, educators, and mental health professionals. A functional model to guide classification, assessment, and treatment of this population has evolved in recent years. In this article, step-by-step recommendations are made for synthesizing assessment information from a particular case toward the development and confirmation of a functional hypothesis. An illustrative example is also provided.

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School refusal behavior is a pernicious problem that disrupts the lives of many children and families and can lead to damaging short- and long-term consequences. In a previous article, the characteristics and functional assessment of school refusal behavior were outlined (Kearney, Lemos, & Silverman, 2004). The reader is also referred to other sources for general information about this population as well as our functional model (Kearney, 2001; 2003; 2005; Kearney & Albano, 2000; Kearney & Silverman, 1996). In this article, we discuss steps for synthesizing assessment materials to assign appropriate, prescriptive treatment for a particular child with school refusal behavior. An illustrative case example is also provided.

According to the functional model, school refusal behavior is generally maintained by one or more of the following conditions:

- To avoid school-based stimuli that provoke a general sense of negative affectivity (anxiety and depression)
- To escape aversive school-based social and/or evaluative situations
- To pursue attention from significant others
- To pursue tangible reinforcers outside of school
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Functional assessment of this population generally involves interviews, child self-report and parent/teacher measures, direct observations, and consultations with school officials to determine which of these reasons are primary and secondary for a particular child who refuses school (see Kearney et al., 2004). Information is thus collected from multiple sources about multiple areas of functioning. A clinician is then faced with the task of integrating this information to generate hypotheses about maintaining functions of school refusal behavior, or to derive a functional profile. We recommend several steps in this process.

## Step 1: Examine ratings from versions of the School Refusal Assessment Scale

The first recommended step toward understanding the functional profile of a particular child with school refusal behavior is to examine ratings from child and parent versions of the School Refusal Assessment Scale (revised edition; SRAS-R) (Kearney, 2002). The SRAS-R is designed to measure the relative strength of the four functional conditions listed above and is typically given to the child (if appropriate) and to both parents. Item means for each functional condition are then calculated from each version and averaged to derive an initial functional profile (see Kearney et al., 2004). This method obviously weights the profile toward parent input

if two parents are available, but we have found this to be desirable in many cases. A clinician may also separately compare item means from the child version to each parent version or to a compilation of both parent versions to derive more specific information.

As this convergence of ratings is completed, a clinician may find one of two patterns. First, substantial agreement across the versions may be evident. Hopefully such agreement will pertain to the precise order of relative strength for each functional condition, but this is rare. More likely, agreement will occur for the primary reason a child is refusing school and perhaps the secondary reason. One should ensure that similar ratings did not result from coercion or some other confound, but in general such agreement portends well for the assignment of appropriate, prescriptive treatment.

A second and unfortunately messier pattern that may be found is substantial disagreement across child and parent versions or between parent versions of the SRAS-R. For example, a child may endorse attention-seeking as the primary function of his or her school refusal behavior, whereas parents may endorse escape from aversive social and/or evaluative situations at school. In addition, a child could endorse one function and his or her parents could endorse two different and separate functions.

Several reasons generally account for such discrepancies. First, multiple functions may indeed be propelling a child's school refusal behavior and different raters are perceptive enough to identify these reasons. For example, a shy child may refuse school in the morning primarily because he or she wishes to remain home with a parent, but he or she may be motivated as well to avoid social gatherings and evaluative performances at school. Different raters may be accurately portraying subtle nuances of a child's behavior.

Second, one party may have answered in a way that is designed to further his or her agenda for therapy. A parent may, for example, insist that a child is anxious about school to cover the fact that the parent has not adequately supervised the child's attendance. Or, a child may claim to be anxious about school when in fact he or she simply wishes to be with friends during the day. Finally, informant variance may result from the fact that someone, often one or both parents, is relatively uninformed about a child's behavior. This often occurs, for example, in cases where a child has surreptitiously missed school for a lengthy period of time or where family members are relatively detached from one another and not well informed about each other's behavior.

An examination of SRAS-R scores may thus give a clinician some initial insight into what maintains a child's school refusal behavior and/or other factors such as lack of parental involvement that need to be addressed in treatment. If agreement is strong and if a particular case is highly urgent in nature, then assignment of prescriptive treatment may proceed with caution. If disagreement occurs or if a particular case is less urgent in nature, then following the additional steps outlined here is recommended.

#### Step 2: Examine other descriptive evidence to corroborate functional hypotheses

If substantial agreement has been found across SRAS-R versions, we still recommend that other descriptive evidence be examined to corroborate the initial functional hypothesis or profile. Functional profiles can, for example, be compared to child and parent interview information and data from standardized child self-report and parent/teacher checklists. Hopefully, agreement across measures will occur (and often does in clear-cut, acute cases). For example, a child who misses school to avoid stimuli provoking negative affectivity may indeed

score high on measures of general anxiety and depression. Similarly, a child who misses school for attention may indeed be rated by parents and teachers as a reassurance-seeking child. Functional profiles can also be matched to interview questions that are similar to SRAS-R items both across interviewers and across time to establish consistency. In this way, a clinician can be more confident about what is truly motivating a child's school refusal behavior.

If substantial disagreement has been found across SRAS-R items, then an examination of other descriptive evidence is crucial. Special attention should be paid to interview information, especially questions that mimic SRAS-R items. A clinician can then compare SRAS-R information to interview information to identify patterns that clarify a particular functional condition. For example, a clinician may have noted that a child met diagnostic criteria for generalized and social anxiety disorders and seemed quite nervous during the interview. This may help confirm the hypothesis that a child is refusing school at least partly for anxiety-based reasons. In many cases, a reinterview process is recommended so a clinician can explore informant discrepancies or recent behavioral changes in more depth. In our clinic for youths with school refusal behavior, for example, we often ask frank questions about such discrepancies and recent events that may have produced a change in functional profile.

SRAS-R ratings should also be compared to child self-report and parent/teacher measures. Patterns of general or social anxiety, attention-seeking, and externalizing behavior problems should be examined because these are closely linked to the functional conditions outlined earlier (see Kearney, 2001). Ratings of family dynamic patterns may help clinicians identify a particular function as well (see Kearney & Silverman, 1995). Ideally, ratings from the SRAS-R and other checklists as well as reinterview information will help clarify a particular child's function for school refusal behavior.

### Step 3: Examine behavioral observation evidence to corroborate functional hypotheses

If substantial agreement has been found among SRAS-R ratings and between SRAS-R ratings and other descriptive information, and if a particular case is not extremely urgent in nature, then we recommend comparing this set of descriptive information with behavioral observations for corroborating functional hypotheses even further. Formal and in-session observations have been detailed previously (see Kearney & Albano, 2000; Kearney et al., 2004) and are not repeated here. However, the general goal is to confirm whether descriptive information matches actual behavior in naturalistic and clinic settings. For example, a child who consistently avoids social interactions at school and appears quite reserved with a clinician should reflect these behaviors in his or her descriptive information. Discrepancies between (1) observations and (2) generally consistent descriptive information are unusual but can happen and should be explored in more depth either via reinterview or consultation with school officials (see step 4).

Behavioral observations are especially critical in cases where substantial disagreement occurs among descriptive measures. Again, these procedures have been outlined previously but involve situations where a child is asked to attend school under certain conditions to confirm or disconfirm a given functional hypothesis. For example, a child may claim that he misses school to avoid stimuli that provoke negative affectivity though his parents claim he misses school for tangible reinforcement outside of school. In this situation, a child may be asked to attend school under conditions that would seem highly favorable to him given his report (e.g., on a Saturday, few people around). If the child is able to attend school under these conditions, then support is gleaned for this functional profile. In addition, this child may be asked to attend school with

substantial incentives, as per parental expectations. If the child is unable to attend school even with these incentives, then the parent report is disconfirmed.

#### Step 4: Examine information from school officials to corroborate functional hypotheses

In all cases of school refusal behavior, consultation with knowledgeable school officials to confirm or disconfirm functional hypotheses is crucial. Although this step is listed last, such consultation may occur at any point during the functional assessment process and, in some cases, should be done immediately. Although a wide variety of information can be collected from school officials (see Kearney & Albano, 2000), questions for purposes of functional assessment should concentrate on a child's avoidance and escape behaviors, other anxiety-based behaviors, attention-seeking behaviors, disruptive behaviors, class attendance record, and peer and academic status.

Substantial disagreement may occur between (1) children and parents and (2) school officials. This is common and may be related to parent-school official conflict, lack of knowledge about a particular child's behavior (especially if a child has not been in school for some time), or discrepant child behaviors at home and school. With respect to the latter, for example, a child may initially refuse school in the morning for attention and then become disruptive at school to be suspended so he or she can enjoy tangible reinforcers outside of school. In cases such as these, a clinician could evaluate patterns of responses from different sources, conduct behavioral observations to minimize discrepancies, and develop parent-school official rapport.

#### Linkage to prescriptive treatment

Once a functional hypothesis has been developed and confirmed, a prescriptive treatment package may be assigned. Prescriptive treatment packages have been linked to each function of school refusal behavior, and multiple packages are needed for cases marked by multiple functions. These treatments are generally designed to eliminate reinforcers derived from school refusal behavior and to enhance skills necessary for anxiety management and family problem-solving. Intervention procedures are described in detail elsewhere (see Kearney, 2001; Kearney & Albano, 2000).

#### Case example

An illustrative sample case is now presented. Celia was an 8-year-old female referred for acute school refusal behavior that persisted for three months. She was a third grader whose prior attendance record was sometimes problematic but always manageable before this academic year. Upon entering third grade, however, Celia reportedly had severe somatic complaints and anxiety surrounding her new teacher and class. Although her parents were unsure of the validity of these new symptoms, their daughter did cry and refuse to move in the morning before school in an effort to stay home.

Initial stages of assessment included a structured diagnostic interview, child self-report measures of various internalizing behaviors, parent and teacher checklists of various internalizing and externalizing behaviors, and a descriptive functional analysis using versions of the School Refusal Assessment Scale-Revised. The clinician scored these versions and saw that Celia claimed she was refusing school primarily to avoid school-based stimuli that provoked a general sense of negative affectivity. Her secondary function was attention-seeking behavior. Her parents, on the other hand, endorsed attention-seeking behavior as the primary and only function of their daughter's school refusal behavior.

Celia claimed in her interview that her teacher was mean and that she did not like the sudden upsurge in homework she was given. She was somewhat reserved during the interview but answered all questions put to her. She met criteria for no mental disorder. Celia's parents, however, outlined a series of misbehaviors on their daughter's part that ranged from noncompliance to minor aggression. They also said the recent birth of their new baby had accelerated Celia's desire to cling to them and stay home from school. In addition, they felt Celia's refusal to attend school represented a worsening problem that had developed over the past three years. Furthermore, they and their pediatrician believed Celia's somatic complaints to be medically unfounded.

Celia's scores on her self-report measures indicated moderate but not high levels of general and social anxiety and little fear or depression. Celia's parents endorsed few internalizing problems except somatic complaints but endorsed considerable attention-seeking and reassurance-seeking behavior on their daughter's part. Interestingly, Celia's teacher and guidance counselor had little to report because Celia was generally well-behaved once in school. However, her attendance record revealed 19 days missed in three months and her grades were suffering as a result.

The clinician thus felt that Celia was likely refusing school for attention and to be home with her mother but that some anxiety about school and recent life changes was possible. To test this hypothesis, the clinician asked Celia's mother to attend her daughter's classroom as a parent helper four days over the next two weeks. Celia's mother reported that Celia had little trouble attending school on those days when she knew her mother would be there, but was still sullen in class. In addition, Celia continued to complain about stomachaches and her homework assignments. This experiment confirmed the clinician's hypothesis that Celia's school refusal behavior was primarily motivated by attention and secondarily motivated by a desire to avoid homework assignments.

Treatment consisted mainly of contingency management. First, Celia was expected to attend school and not display morning tantrums. Success in doing so was rewarded with special time with her mother at night (stories, play time) and a one-on-one homework session with her father to help finish make-up work and current assignments. Failure in doing so was punished using early bedtime, which Celia dreaded. In addition, the clinician engaged in somatic management strategies with Celia to reduce anxiety symptoms and to control stomach pains. Treatment over a 7-week period resulted in the resumption of full-time school attendance.

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