Brief Cognitive-behavioural Treatment for Anxiety-disordered Children Exhibiting School Refusal

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This study evaluated the efficacy of a brief intervention programme for 20 anxiety-disordered children exhibiting school refusal. Treatment consisted of individual child cognitive-behaviour therapy and parent/teacher training. Children underwent a comprehensive assessment before and after treatment, and at a 3-month follow-up. Marked improvements were evident on nearly all measures, including school attendance. The findings signal the need for a controlled evaluation in order to establish the efficacy of this cost-efficient intervention.

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INTRODUCTION

School refusal is a challenging problem for mental health therapists and occurs in approximately 1% of school-aged children (see reviews by Burke and Silverman, 1987; King and Ollendick, 1989; King et al., 1996). Berg and colleagues have noted that school refusal involves difficulties in school attendance, emotional distress at the prospect of going to school but an absence of antisocial characteristics (Berg et al., 1969). On psychological examination, many of these children have an anxiety or phobic disorder (see Ollendick and Mayer, 1984; Last et al., 1987; Last and Strauss, 1990). School refusal has a complex aetiology with temperament characteristics, school experiences and family influences contributing to the onset and maintenance of the problem (King et al., 1995). Also stressful life events at home or school frequently occasion the onset of school attendance difficulties (Blagg, 1987). Common precipitants include absence from school due to illness, traumatic experience at school or change in family circumstances such as death of a parent.

Behavioural interventions such as in vivo exposure and contingency management have been successfully used in the management of school refusal (Kennedy, 1965; Lazarus et al., 1965; Blagg and Yule, 1984). Reflecting a more contemporary clinical approach, Mansdorf and Lukens (1987) used cognitive-behavioural procedures in the treatment of two separation-anxious youngsters exhibiting school refusal. In addition to graduated school return and contingency management, subjective anxiety was successfully reduced through cognitive restructuring. More recently, we proposed a treatment model involving child therapy and parent/teacher training (King et al., 1996). Child therapy entails the use of behavioural and cognitive procedures directly with the youngster. This level of intervention aims to help the child cope with the stressors (e.g. separation from mother, peer bullying and teasing) associated with school return or regular school attendance. However, the involvement of parents and teachers is usually essential for...
optimum therapeutic results (Sanders and Dadds, 1993). Parent/teacher training focuses on the development of child behaviour managements skills that can be used at home or school to facilitate regular and voluntary school attendance (Blagg, 1987).

Bearing in mind these clinical requirements, we have trialled a cognitive-behavioural treatment programme for school refusal that incorporated child therapy and parent/teacher training. The major behavioural goal of the programme was school return. In order to minimize the complications arising from prolonged school absenteeism such as falling behind at school and positive reinforcement for staying at home, we elected a fairly brief treatment period (4 weeks) in which to achieve the treatment goal. Of course, the notion of brief therapy is also consistent with the ever-increasing emphasis on cost-effectiveness in the provision of clinical services. In this paper we present preliminary findings on the efficacy of our intervention programme for anxiety-disordered children exhibiting school refusal.

SUBJECTS

Participants included 20 children and adolescents (13 boys and seven girls) referred to the School Refusal Clinic at the Centre for Developmental Psychiatry, Monash Medical Centre. The children (aged 6–14 years, mean = 9.9 years) met Berg et al. (1969) criteria for school refusal: (a) persistent difficulties in attending school; (b) severe emotional upset, including excessive fearfulness, temper outbursts or complaints of feeling ill when faced with the prospect of going to school; (c) at home with parent’s knowledge when the youngster should be at school; (d) absence of antisocial characteristics such as stealing, lying and destructiveness. Persistent school attendance problems were evident for all children. At the time of referral, 30% of children were completely absent from school, 60% had intermittent or partial school attendance problems and 10% were attending school but were highly anxious and resistive about going to school.

All children received a primary anxiety disorder diagnosis on the basis of a structured clinical interview (details are described below). Primary diagnoses included adjustment disorder with anxious mood \((n = 9, 45\%)\), separation anxiety disorder \((n = 4, 20\%)\), anxiety disorder NOS \((n = 3, 15\%)\), social phobia \((n = 2, 10\%)\), over-anxious disorder \((n = 1, 5\%)\) and obsessive-compulsive disorder \((n = 1, 5\%)\). Ten children had comorbid diagnoses, namely, oppositional defiant disorder \((n = 4, 20\%)\), depressive disorder \((n = 2, 10\%)\), separation anxiety disorder \((n = 2, 10\%)\) and simple phobia \((n = 2, 10\%)\).

Most of the children had experienced school attendance problems for several years and had been unsuccessfully treated by school counsellors, psychologists or psychiatrists. Children were excluded from the project if they had intellectual or physical disabilities, displayed psychotic symptoms or suicidal behaviour, were taking anti-anxiety or anti-depression medication, had a current physical illness that precluded school attendance or whose parents were involved in acute marital breakdown.

INTERVENTION

All 20 children received our cognitive-behavioural treatment programme. As already noted, this involved child therapy and parent/teacher training. Therapists were five registered psychologists (one man and four women).

Child Therapy

Children underwent \(6 \times 50\) min individual therapy sessions, directed at helping the child overcome school attendance difficulties and associated anxiety. Kendall’s work on the cognitive-behavioural treatment of childhood anxiety disorders was particularly influential in the development and refinement of the treatment protocol (Kendall et al., 1990, 1992; Kendall, 1994) as well as that of Ollendick and colleagues (Friedman and Ollendick, 1989; Ollendick, 1995).

Session 1 involved rapport building and identifying specific anxiety-provoking situations at school or home and how the child responds to that anxiety. This session also included a rationale for the treatment programme and individual goal setting. Sessions 2 and 3 focused on training in coping skills to deal with anxiety-provoking situations such as parental separation or being teased at school. Training the child in relaxation, particularly cue-controlled relaxation and differential relaxation was helped by the provision of a personalized relaxation cassette for use outside the therapy sessions (Bernstein and Borkovec, 1973; Cautela and Groden, 1978). Teaching the child to recognize and assess self-talk during anxiety-provoking situations was also a major focus. The difference between anxiety-producing and anxiety-reducing self-talk was
emphasized. Pictorial material involving cartoons and ‘thought bubbles’ assisted instruction in the relationship between thoughts, feelings and behaviour, and the development of more appropriate self-talk. Teaching the child appropriate assertive behaviours was also included in the coping skills sessions. This was aimed at preparing children for answering questions about school absenteeism and facilitating the social involvement of withdrawn children. Yet another focus was self-evaluation and self-reward.

During sessions 4 to 6, the child was required to apply these skills to imaginal and in vivo anxiety-provoking situations. Typically, anxiety-provoking situations were presented in hierarchical order ranging from least anxiety-provoking through to most anxiety-provoking. Thus our school avoidant children anxious about school return were required to undergo graduated school re-entry. This often commenced with a single class or half day of school attendance. Once this had been successfully accomplished, the amount of time at school was gradually increased until the child was able to attend school for the whole week. Other fears, such as the fear of riding a school bus, were treated via graduated exposure or desensitization. The last session comprised a review of concepts and skills, as well as an emphasis on the likelihood of stressful events in the future and the role of coping skills (relapse prevention). Individual child therapy sessions were facilitated by interactive discussion, written materials, modelling, behaviour rehearsal, social praise and homework tasks.

**Parent/Teacher Training**

Parents received 5 × 50 min sessions of training in child behaviour management skills aimed at school attendance. The five sessions with the parents were interspersed over the duration of the 4-week treatment period. Session 1 consisted of rapport building and an explanation of the treatment programme. There was an emphasis on the role of caregivers in helping children overcome anxiety problems and school refusal. Sessions 2 and 3 consisted of training in antecedent stimulus control and contingency management procedures (cf. Lazarus et al., 1965; Ayllon et al., 1970; Vaal, 1973). Training focused on the establishment of smooth morning routines, and the ignoring of somatic complaints and negative comments about school. The use of social or tangible reinforcement for positive coping behaviour and school attendance were emphasized. Sessions 4 and 5 involved a discussion of progress in efforts to establish regular school attendance. An important aspect involved trouble shooting problems such as parental guilt or fear of rejection by the child as a result of applying firm consistent discipline. Parent training utilized written guidelines, modelling, rehearsal and feedback.

Typically, one meeting was held with teachers at the school to discuss the treatment plan and role of teachers in facilitating regular school attendance. Emphasis was placed on practical behaviour management strategies such as positive greeting and planned activities. Teachers were also encouraged to plan a buddy support system to help overcome social isolation or peer rejection and teasing. In addition, there was regular telephone contact with teachers in order to monitor the child’s progress at school and clarify treatment issues.

**Therapy Manual**

Therapists followed a detailed therapy manual prepared for the purposes of the investigation. Factors such as the age of the child, the home situation and school idiosyncrasies required the treatment protocol to be flexibly applied (cf. Kendall, 1994).

**ASSESSMENT**

Consistent with the principle of multi-method assessment, a range of measures were used in our treatment evaluation (Ollendick and Hersen, 1993; King et al., 1995). Each assessment was conducted over a 2-week period. Assessments were performed before and after treatment, and at a 12–14-week follow-up. Follow-ups were conducted immediately after the first school holidays which is known to be a high risk time that often precipitates relapse (Blagg, 1987).

**Problem-specific Measure (School Attendance)**

Each child’s school attendance record was checked over the assessment period (2 weeks). The number of days present at school were tallied and converted to a percentage. Random phone calls to each teacher on a proportion of days across each of the assessment periods confirmed the accuracy of the school attendance records.
Self-report Measures
A battery of self-report instruments were administered to measure fear, anxiety and depression. The following instruments were selected for their psychometric strengths and developmental sensitivity: the Fear Survey Schedule for Children—II (FSSC-II; Gullone and King, 1992), the Revised-Children’s Manifest Anxiety Scale (R-CMAS; Reynolds and Richmond, 1978), and the Children’s Depression Inventory (CDI; Kovacs, 1981). Children also completed a ‘fear thermometer’ (FT). Using a visual analogue scale ranging from 0 (not scared) to 100 (very scared), children were required to provide a rating of their emotional distress associated with school attendance. The child was required to identify the worst day over the past 2 weeks and rate how afraid he/she felt about going to school. Much research attests to the reliability and validity of the fear thermometer and its variants (Klein-knecht and Bernstein, 1988).

The Self-Efficacy Questionnaire for School Situations (SEQSS; Heyne et al., 1998) was used to assess changes in children’s perceived ability to cope with specific anxiety-provoking situations at school (cf. Kendall, 1994). This instrument addresses 12 different possible anxiety-provoking situations commonly experienced by school-refusing children. Examples of anxiety-provoking items include separation from parents, handling questions about school absenteeism and being tested or bullied. Children were required to rate their ability to cope on a 5-point scale that ranged from really sure I could not cope (1) to really sure I could cope (5). Total scores range from 12 to 60 with higher score reflecting higher overall self-efficacy. Although further research is required on its psychometric properties, the SEQSS appears to have promising reliability and validity (Heyne et al., 1998).

Parent Measures
The Child Behaviour Checklist (CBCL; Achenbach and Edelbrock, 1983) was completed by parents for each child. The CBCL includes 118 behaviour problem items which are rated by the parent on a 3-point scale as to how well each describes the child. As well as a Total Behaviour Problems score, this inventory yields scores for two broad band factors—Internalizing and Externalizing (Achenbach and Edelbrock, 1983). Reliability and validity are well established and the instrument is frequently used in treatment evaluations (e.g. Daugherty and Shapiro, 1994; Kendall, 1994).

Teacher Report
The Child Behaviour Checklist—Teacher Report Form (TRF) (Achenbach and Edelbrock, 1983) was completed by the main teacher for each child. This allowed for the assessment of internalizing and externalizing problems, from the perspective of the teacher. The TRF has much research support in terms of its psychometric properties and is often used as a treatment outcome measure (Daugherty and Shapiro, 1994; Kendall, 1994).

Clinician Rating
At the end of the assessment period, each child received a clinician rating as to his/her overall psychological, social and school functioning using the Global Assessment of Functioning (GAF) Scale (American Psychiatric Association, 1987). The GAF Scale ranges from 1 to 90 (e.g. 1–10 persistent danger of hurting self or others; 41–50 serious impairment in school or social functioning; 71–80 transient and unexpected reactions to psychosocial stressors; 81–90 absent or minimal anxiety).

Diagnostic Evaluation
At each assessment period the child and his/her parents underwent separate structured diagnostic interviews. Diagnoses were based on a combination of child and parent interview data. The Anxiety Disorder Interview Schedule for Children (ADIS-C) and a parallel version for the parents (ADIS-P) were used (Silverman and Nelles, 1988). The ADIS-C/P is based on the DSM-III-R classification of psychopathology (American Psychiatric Association, 1987). Research findings attest to the reliability of the ADIS-C/P (cf. Silverman and Eisen, 1992; Rapee et al., 1994). Importantly, this structured diagnostic interview schedule has been used to determine ‘caseness’ in several treatment outcome studies (Kendall, 1994; Barrett et al., 1996).

RESULTS AND DISCUSSION
Table 1 presents the means and standard deviations for the various measures at each of our assessments. Matched pair t-tests were used to determine the statistical significance of changes from pretreatment to posttreatment, and from pretreatment to follow-up. Children underwent significant changes from pretreatment to posttreatment on nearly all measures: school attendance, child self-report (Fear
Thermometer, FSSC-II, R-CMAS, CDI and SESSQ), parent report and clinician rating (GAF). In particular, marked improvements were evident for our cohort in the percentage of school attendance from pretreatment to posttreatment (46.50% and 86.75%, respectively). In addition to improvements in school attendance, treatment appears to have resulted in reduced negative affect (fear, anxiety and depression) and increased confidence to cope with anxiety-provoking situations such as separation from parents and handling questions about school absenteeism. Parent ratings of internalizing problems and clinician ratings of global functioning also show similar patterns of improvement. Moreover, t-tests revealed significant changes on all measures from pretreatment to follow-up, thus indicating maintenance of treatment gains (see Table 1).

In addition to showing that our cohort underwent significant changes, we must also address the clinical significance of the changes produced (Kazdin, 1977). Focusing on school attendance, we believe that a minimum 90% attendance is what might be considered ‘normal’ for our cohort (cf. Kearney and Silverman, 1990). At our initial pretreatment assessment, all but three of our youngsters failed to exhibit a normal level of school attendance. Following treatment, however, 15 of the 20 children exhibited normal attendance. Follow-up assessment revealed that one fewer of our successfully-treated children succeeded in maintaining normal school attendance (14 out of 20).

There were also marked improvements in relation to the anxiety disorder ‘caseness’ of our cohort. At our initial pretreatment assessment, all 20 children met diagnostic criteria for an anxiety disorder. Following treatment of school refusal and associated anxiety disorders, 17 of the 20 children (85%) no longer met the criteria. The proportion of children without an anxiety disorder was unchanged at our follow-up assessment (n = 17; 85%). To our knowledge, this is the first study to have investigated whether helping children overcome school attendance problems is associated with a change in their diagnostic status. Our findings clearly suggest that brief cognitive-behavioural intervention is an efficacious treatment for the psychopathology (anxiety disorders) associated with school refusal.

Several clinical issues emerged during our treatment evaluation. Above all, flexibility was required in the delivery of the treatment protocol (cf. Kearney and Silverman, 1990). This was necessitated by different patterns of clinical presentation in the child, changing family circumstances and varying school requirements. Several children and

Table 1. Means, standard deviations and significance for the various measures

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pretreatment</th>
<th>Posttreatment</th>
<th>Follow-up</th>
<th>t(pre-post)</th>
<th>t(pre-follow-up)</th>
</tr>
</thead>
<tbody>
<tr>
<td>School attendance</td>
<td></td>
<td></td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of days present</td>
<td>46.50 (40.23)</td>
<td>86.75 (26.77)</td>
<td>78.68 (38.58)</td>
<td>5.28²</td>
<td>3.89²</td>
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<tr>
<td>Child self-report</td>
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<tr>
<td>FT</td>
<td>57.00 (24.96)</td>
<td>25.35 (25.36)</td>
<td>14.95 (22.85)</td>
<td>5.92²</td>
<td>4.19²</td>
</tr>
<tr>
<td>FSSC-II</td>
<td>132.65 (33.58)</td>
<td>119.60 (30.14)</td>
<td>113.10 (28.75)</td>
<td>2.92³</td>
<td>3.08³</td>
</tr>
<tr>
<td>R-CMAS</td>
<td>56.04 (14.87)</td>
<td>47.74 (6.76)</td>
<td>45.91 (5.21)</td>
<td>6.21²</td>
<td>5.25²</td>
</tr>
<tr>
<td>CDI</td>
<td>14.90 (9.04)</td>
<td>7.95 (8.62)</td>
<td>4.85 (3.05)</td>
<td>4.41²</td>
<td>4.87²</td>
</tr>
<tr>
<td>SESSQ</td>
<td>41.00 (8.41)</td>
<td>50.58 (6.85)</td>
<td>53.40 (5.28)</td>
<td>5.92²</td>
<td>6.08²</td>
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<tr>
<td>Parent report</td>
<td></td>
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<tr>
<td>CBCL Int Mother</td>
<td>73.90 (6.58)</td>
<td>57.53 (11.67)</td>
<td>54.95 (11.38)</td>
<td>7.84²</td>
<td>7.32²</td>
</tr>
<tr>
<td>Father</td>
<td>66.29 (12.65)</td>
<td>52.38 (11.87)</td>
<td>51.00 (18.66)</td>
<td>5.33²</td>
<td>3.78²</td>
</tr>
<tr>
<td>Teacher report</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>TCBCL Int</td>
<td>63.00 (11.58)</td>
<td>55.37 (11.22)</td>
<td>51.56 (12.13)</td>
<td>2.08</td>
<td>3.88³</td>
</tr>
<tr>
<td>Clinician rating</td>
<td></td>
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<tr>
<td>GAF</td>
<td>64.05 (5.69)</td>
<td>77.50 (9.11)</td>
<td>77.95 (9.85)</td>
<td>6.62²</td>
<td>6.96²</td>
</tr>
</tbody>
</table>

¹Numbers in parentheses are standard deviations.
²p < 0.001.
³p < 0.01.

FT, Fear Thermometer; FSSC-II, Fear Survey Schedule for Children-II; R-CMAS, Revised-Children's Manifest Anxiety Scale; CDI, Children's Depression Inventory; SESSQ, Self-Efficacy School Situations Questionnaire; CBCL, Child Behavior Checklist; TCBCL, Teacher Report Form of the Child Behavior Checklist; GAF, Global Assessment of Functioning; t Scores reported for R-CMAS, CBCL and TCBCL.
their caregivers received extra sessions with the programme being extended into a fifth or sixth week. Given the limitations of our design, it is not possible to quantify the relative efficacy of child therapy and parent/teacher training in our treatment package. Similar to other researchers (e.g. Blagg and Yule, 1984; Mansdorf and Lukens, 1987), however, our clinical impressions is that child therapy and parent/teacher training were both necessary in all cases. Child cognitive-behaviour therapy played an important role in preparing the child for school return, but we still encountered in many children an initial reluctance or procrastination about school return. Parent/teacher training was crucial in empowering caregivers with the necessary behaviour management skills and confidence to remain steadfast about school attendance.

Our findings are consistent with those of other studies utilizing brief cognitive-behaviour therapy with school-refusing children (Mansdorf and Lukens, 1987). As well as being efficacious, it is noteworthy that our treatment programme was evaluated as being highly acceptable by the children and their caregivers on a ‘consumer satisfaction’ questionnaire (cf. Gullone and King, 1991). Completed at the end of the treatment programme, the questionnaire addressed the client perceptions of the major aspects of intervention—goals, treatment strategies and outcomes. Given our findings on the efficacy and acceptability of the cognitive-behavioural treatment programme, a controlled investigation is now required. Should a more rigid evaluation confirm our initial findings, we believe that cognitive-behavioural therapy should be the treatment of first choice for school-refusing children.

CONCLUSIONS

School refusal is a challenging problem for mental health therapists with many empirically questionable approaches being utilized in treatment. We reported positive results for a brief cognitive-behavioural treatment programme that incorporated child therapy and parent/teacher training. Twenty anxiety-disordered young people exhibiting school refusal participated in the study. Our treatment programme was found to provide a useful structure for the management of school refusal. Importantly the treatment approach remained sufficiently flexible to be responsive to different patterns of clinical presentation in the child, changing family circumstances and varying school requirements. Significant improvements occurred on all measures, including school attendance—the most crucial of the dependent variables. As a result of treatment, many of the children also no longer met diagnostic criteria for an anxiety disorder. Given these encouraging clinical results as well as the acceptability of the treatment package, a more rigid evaluation is now required.

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