Increasing School Attendance and Decreasing Mental Health Symptomology for Children and Youth with School Refusal Behaviour Using a Functional Model and Cognitive Behavioural Therapy

by

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Dedication

I would like to dedicate this thesis to my mom, who has truly shown me the meaning of infinite love and unconditional positive regard. Thank you for nurturing in me a curiosity about the world, a thirst for knowledge, and an ability to see light in the darkest of times. You are and will forever be an inspiration to me.
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Abstract
School refusal behaviour and mental health concerns often co-occur and can increase the risk of negative short- and long-term outcomes for affected children and youth. This study sought to identify whether the use of a functional model, cognitive and behavioural techniques, and a collaborative approach would increase school attendance and decrease the severity of mental health symptoms for selected participants. The multidisciplinary team consisted of school attendance counsellors from local school boards, Hotel Dieu Hospital supervising clinicians, St. Lawrence College faculty and students, and the Centre for Behavioural Studies. Two participants completed the study; a 14-year-old male and a 12-year-old female. A functional model of school refusal behaviour was used to identify the variables maintaining the participants’ behaviour to inform treatment planning. Individualized interventions were developed to address these functional variables using cognitive behavioural therapy (CBT) and were implemented in the school and home settings. In addition to individual sessions, a five-session psychoeducational workshop was provided to parents of participants covering information about school-refusal behaviour, mental health, and cognitive and behavioural strategies to support their children. Results were nonsignificant for both student participants, thereby disconfirming the study’s hypothesis. However, there were several uncontrolled variables that may have influenced the outcome, including family support and parent mental and physical health. Despite these limitations, this study contributes to research on the strength of a collaborative approach for school refusal behaviour. Future research should focus on the contingencies in the environment and ensure that treatment sessions are adequately paired with reinforcement to facilitate participant engagement.
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Chapter I: Introduction

In Ontario each year, up to 20% of children will experience a concern pertaining to their mental health, yet there are currently over 12,000 children in the province on waitlists to receive mental health services (Children’s Mental Health Ontario [CMHO], 2017). The limitation of resources for children and youth with mental health concerns can lead to the exacerbation of symptoms and leave families in crisis. In fact, the number of child and youth emergency room visits related to mental disorders has risen by 54% in the last 10 years, indicating that the mental health needs of children and youth are an increasingly pressing issue (CMHO, 2017). Anxiety disorders are the most extensively-occurring mental health disorders among children and youth and are associated with significant academic and social impairment (Power, 2003; Settipani, O’Neil, Podell, Beidas, & Kendall, 2013).

The school environment is integral for the development of academic, social, and vocational skills. However, students with mental health concerns may experience school as aversive due to negative cognitions or somatic symptoms, such as nausea or dizziness, associated with school or school-related stimuli (Kearney & Graczyk, 2014). They may engage in behaviour to avoid school and the distress associated with it, creating a pattern of irregular attendance. Sporadic attendance is correlated with suicidal behaviour, substance use, and increased likelihood of permanent school drop out, and can lead to future relationship and employment issues (Kearney, 2008). To encapsulate the variety of behaviours that children and youth may engage in to escape or avoid school attendance, Kearney and Silverman (1996) offered the following definition:

Youth aged 5-17 years who, to a substantial extent, (a) are completely absent from school, and/or (b) initially attend then leave school during school days, and/or (c) go to school following behavior problems such as morning temper tantrums, and/or (d) display unusual distress during school days that precipitates pleas for future nonattendance. (p. 345)

Due to the negative short- and long-term consequences associated with school-refusal behaviour and the limited resources available to children and youth with mental health concerns, it is vital to involve parents and mental health and school-based professionals, using a collaborative approach and evidence-based methods, to increase the efficacy of programs designed to increase school attendance (Kearney, 2003).

School refusal is a complex problem that can involve multiple people, settings, and contextual variables, and is related to a plethora of negative short- and long-term outcomes. As such, it is essential to utilize as many resources as possible and take a unified approach involving parents, students, and mental health and school-based professionals. To address the proximal and distal variables often neglected in the literature on school-refusal behaviour, Kearny (2008) developed an interdisciplinary model for school refusal behaviour, emphasizing the importance of considering parent, school, peer, and community factors. The addition of students to an interdisciplinary team can enhance the efficacy of programs designed to increase school attendance for several reasons. Most notably, undergraduate students completing practicums are in a unique position to apply and practise the knowledge and skills gained from course material and effect a positive change for youth and families who may otherwise be waiting for services for an undetermined period, as well as develop skills that will aid in preparation for future employment and academic pursuits (Simons et al., 2012).
The functional model of school refusal, developed by Kearney and Silverman (1996), is a framework for understanding the school-refusal behaviour of children and youth, assessing the function of the behaviour, and applying intervention techniques that are tailored to the identified function(s). Employing assessment methods that evaluate both the function and symptomatology of school-refusal behaviour may provide more information about a child or adolescent than either alone, and thereby facilitate the development of interventions that are individualized and address the functional components of school refusal (Kearney & Silverman, 1996).

The functional model can guide treatment by identifying factors that contribute to school refusal, which are often most effectively addressed by using components of cognitive behavioural therapy (CBT). CBT is based on a model of understanding human experience by examining the interaction between thoughts, feelings, bodily sensations, and behaviour. CBT uses both cognitive and behavioural techniques, such as relaxation training, thought challenges, and exposure to feared stimuli, to address the psychological, physical, and behavioural components of distress. There is an abundance of research supporting the efficacy of CBT to reduce mental health symptoms, which, along with its short duration and long-term results, make it the leading treatment for a multitude of psychological disorders (Vinci, Coffey, & Norquist, 2015). CBT has also been shown to be an effective intervention for school-refusal behaviour (Heyne, Sauter, Ollendick, Van Widenfelt, & Westenberg, 2014).

This thesis is being completed as part of the School Attendance Project and involves a collaboration between the mental health unit at a local hospital, clinicians, school attendance counsellors, faculty and students of the Honours Bachelor of Behavioural Psychology Degree Program at St. Lawrence College, and the Centre for Behavioural Studies. The School Attendance Project was developed as a pilot study under the Centre for Behavioural Studies with the purpose of effecting positive change in the lives of children and youth in the community with school-refusal behaviour and mental health symptoms. The current study aims to increase participants’ school attendance and decrease the severity of mental health symptoms, as well as provide psychoeducation to parents about school refusal, mental health, and cognitive and behavioural techniques that can be used to decrease mental health symptoms. It is hypothesized that the use of a functional model and CBT, along with the use of a collaborative approach involving parents and mental health and school-based professionals, should increase school attendance and decrease mental health symptomatology among selected participants.

**Thesis Overview**

This thesis includes chapters covering a review of the literature, the method in which the research was implemented, results of the study, and an interpretation and discussion of the results. In the literature review, an analysis of the current research on evidence-based techniques for increasing school attendance, decreasing mental health symptomatology, and involving parents and multiple professionals to increase the efficacy of programs for children and youth is presented. The method section describes the participants, research design, setting, materials, assessment measures, and the procedures for implementing the intervention. The results section presents the baseline and intervention data, assessment results, visual representations of the assessment and intervention data, and a statistical and visual analysis of the obtained results. A review of the strengths and limitations of this study, as well as an interpretation of the results and implications, is presented in the discussion and conclusion section.
School Refusal Behaviour and Mental Health

School refusal behaviour (SRB) is associated with a variety of negative short- and long-term outcomes, including physical, psychological, social, and employment difficulties (Kearney, 2008). Youth who miss a significant amount of school have a greater likelihood of permanently dropping out of school, which limits the opportunities available for them to develop academically and socially and increases the probability of future vocational and social impairment (Kearney, 2008). Children and youth may engage in SRB for many reasons, including avoidance of school and related stimuli, escape from evaluative situations, access to attention from significant others, or access to tangible items (Kearney, 2008). Mental health symptoms can result in significant functional impairments and are associated with avoidance and escape behaviours, therefore increasing the likelihood that children and youth with mental health concerns will engage in SRB.

Mental health symptoms are a barrier to regular school attendance for many youth, with research indicating that parental behaviour is highly influential in the initial development and continuation of youth anxiety, and that family dysfunction is a predictor of school-refusal, with parent-child conflict, codependency, and poorly defined roles as dysfunctional family process that contribute to school-refusal (Carless, Melvin, Tonge, & Newman, 2015; Settipani, O’Neil, Podell, Beidas, & Kendall, 2013). Parent mental health concerns, such as anxiety and depression, may also complicate family dynamics, intensify parent-child conflict, and decrease parents’ ability to support their child, thereby increasing the likelihood of school-refusal and exacerbating the behaviour of youth already engaging in school-refusal (Carless et al., 2015). In comparison to parents with low anxiety, parent anxiety at a clinically significant level has been associated with inadequate treatment outcomes for youth treated with CBT for anxiety (Settipani et al., 2013). Anxiety disorders and depression are often comorbid, especially when anxiety has been present for a significant amount of time without intervention and are associated not only with symptoms such as negative thoughts about the self and others, but also impairment in functioning across all domains of life (Swan & Kendall, 2016). In consideration of these findings, it is therefore essential to employ an approach to school refusal that provides information and teaches skills to parents and utilizes evidence-based interventions. Targeting both child and parent mental health, when applicable, is vital to increase the positive effects of interventions for school-refusal behaviour.

Enhancing Outcomes Using a Collaborative Approach

As school-refusal is a complex issue involving many settings and individuals, effective treatment approaches involve multiple professionals. Although school-based professionals are not typically trained to provide mental health care, utilizing their expertise and connection with students, as well as offering them additional training, can facilitate the development and delivery of effective interventions (Power, 2003). Kearney (2008) emphasizes the need to address the proximal and distal factors in each student’s case and individualize interventions based on this information, which entails focusing on the circumstances surrounding family, social, school, and community relationships and their impact on SRB. He calls for professionals to develop consistency among their methods of assessment and ensure that all relevant factors are taken into consideration when conducting assessment, developing interventions, and providing service delivery (2008). Collaboration between mental health and school-based professionals enhances
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intervention planning and delivery by ensuring that information from multiple sources is incorporated and resources for service delivery are created by mobilizing professionals in multiple domains of a child’s life. This increases the likelihood that interventions are applied consistently and that vital aspects of the situation are addressed. Therefore, to ensure treatment efficacy it is essential to employ an approach to school refusal that involves professionals across domains working collaboratively.

A collaborative approach for school refusal may be strengthened by the addition of undergraduate students completing practicums, as evidenced in a study by Simons et al. in 2012. The researchers collected data from 38 college students and their supervisors, using a variety of self-report measures, including questionnaires and rating scales, to assess the impact that experiential learning through a practicum or internship has on students’ development of skills and knowledge in their area of study (Simons et al., 2012). Students and supervisors both reported that fieldwork provided students with a greater understanding of the content studied and ability to practice cultural competence, as well as assisting the agency (Simons et al., 2012). Students played a vital role in agencies without adequate staff or funding by completing tasks for their supervisors, such as conducting assessments or completing paperwork, that may otherwise take longer to complete (Simons et al., 2012). In fact, students in the study that delivered behavioural services for children with autism were selected to complete their practicum at an agency that was required to reduce their in-home services because of funding, which directly attests to the benefits of utilizing students in the delivery of services, especially within agencies with long waitlists or few qualified professionals (Simons et al., 2012). Consistent with the research on experiential learning, the data collected in this study indicated that practicum and internship programs are beneficial for everyone involved, which further underscores the benefits of utilizing a collaborative approach that involves undergraduate students (Simons et al., 2012).

Due to the significant role that parent behaviour plays in SRB, it is necessary to also involve parents in treatment efforts for youth engaging in school-refusal. In a randomized clinical trial by Settipani et al. in 2013, for youth whose families scored high on measures of psychological control and emotional involvement, which indicated that they displayed a high degree of psychological control over their children and were overly involved in their lives, treatment including a component to address these factors may decrease the time it takes for youth to achieve symptom reduction. Individuals who were between the ages of 7 and 14 and met the criteria for an anxiety disorder were selected to participate in the study, and individuals with psychotic symptoms, intellectual disability, severe medical problems, or taking medication for anxiety or depression were excluded (Settipani et al., 2013) Participants were randomly placed into either an individual or family CBT condition and received 16 weekly CBT sessions (Settipani et al., 2013). Structural equation modeling was used to assess the relationship between youth anxiety and parent factors, analyzing six variables: child anxiety, based on diagnostic criteria and clinician severity rating using the Anxiety Disorders Interview Schedule for Children (ADIS-C/P) and Child Behavior Checklist (CBCL) scores, parent anxiety assessed using the State-Trait Anxiety Inventory (STAI), maternal psychological control as measured by Children’s Report of Parental Behavior Inventory (CRPBI-30), and family affective involvement and control, measured using the Family Assessment Device (FAD) (Settipani et al., 2013). For all 6 variables, scores decreased over the length of the study, indicating that family involvement may enhance treatment outcomes (Settipani et al., 2013). An explanation for this may be related to how parent factors can contribute to the maintenance of mental health symptoms; high parental control and involvement may limit opportunities for youth to develop healthy coping strategies.
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and be exposed to feared situations (Settipani et al., 2013). Avoidance of feared situations increases the level of anxiety experienced in that situation, serving to maintain the anxiety that provoked the avoidance in the first place. If parental control is diminished, youth are given more freedom to engage in activities that challenge their anxiety, which may facilitate the development of appropriate coping skills and self-efficacy, leading to reductions in anxiety (Settipani et al., 2013).

Another study by Lebowitz, Omer, Hermes, and Scahill (2014) addressed parent behaviour by delivering a program specifically designed for parents of children with anxiety disorders. The parents of 10 children between the ages of 9 and 13 participated, attending 10 sessions covering topics conducive to modification of parent behaviour, including learning how to manage disruptive behaviour, access available supports, and model appropriate coping skills (Lebowitz et al., 2014). Sixty percent of children whose parents participated in the study were identified as showing improvement, as rated by scores on the CGI-Improvement scale, with decreases demonstrated in parent accommodation and child depressive symptoms (Lebowitz et al., 2014). These results suggest that providing information and training to parents is an effective method of altering parent behaviour in a manner that can positively influence their children’s mental health symptoms.

Functional Model

Assessing the function of a behaviour is essential to ensure that the reason for the behaviour is addressed when designing interventions for school-refusal. Youth may benefit from nonattendance in many ways, including accessing desirable items or activities, receiving attention, and avoiding or escaping situations or stimuli associated with distress (Kearney, Lemos, & Silverman, 2004). If the motivating factor that drives the behaviour is not taken into consideration, it is not likely that efforts to influence the behaviour will be successful. To establish consistency among professionals working with school-refusing youth, Kearney and Silverman (1996) developed a functional model, proposing four potential functions of SRB: avoidance of school-related stimuli that generates negative affectivity, escape from unpleasant social or performative situations, pursuit of attention, and pursuit of reinforcing items (Kearney et al., 2004). Youth who engage in SRB for the first two functions may benefit from interventions that focus on the development of coping and problem-solving skills, while the last two functions can be effectively addressed with behavioural strategies that increase the reinforcement value of school attendance and decrease access to reinforcement when at home (Kearney et al., 2004). It is possible that youth may refuse school for more than one function, especially when they have already missed a significant amount of school time, which is why it is ideal to comprehensively assess the functional conditions influencing the behaviour and incorporate this information into treatment planning (Kearney et al., 2004). The School Refusal Assessment Scale (SRAS) and its revised version (SRAS-R) were designed to assess the function of SRB using parent and child Likert ratings for statements related to school and school-related stimuli (Kearney et al., 2004). The SRAS and SRAS-R are intended to be used as a component of functional assessment for school-refusal, as results can provide an understanding of the variables that contribute to SRB (Kearney et al., 2004). Previous research indicates that categorizing youth who engage in SRB into the form that their behaviour takes is questionable, as behaviour can rapidly shift forms, but the underlying variables that maintain SRB are often stable. For example, a child may desire attention from their parents and initially complain of physical ailments, such as headaches or stomach aches, to avoid attending school. However, this behaviour may eventually change to the child displaying oppositional behaviour when presented...
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with instructions or requests from parents to get ready for school or leave for school in the morning. Therefore, classification based on behavioural function is more likely to yield positive results than that based on behavioural form (Kearney, 2007).

Research by Kearney (2007) sought to identify whether the functional variables associated with SRB were more valuable than the form that the behaviour takes in assessing the severity of school-refusal. The study included 222 children and youth, and their parents, who had been referred to a specialized outpatient clinic for SRB over a 15-year period, with the majority of participants coming from single parent homes and missing roughly 40% of school days in the present school year (Kearney, 2007). Participants displayed a variety of forms of SRB, such as missing a significant amount of school time, attending late on a regular basis, engaging in tantrum behaviour, and experiencing extreme distress related to school (Kearney, 2007).

Participants and their parents were assessed using multiple measures, including interviews, self-report measures, questionnaires, and observations of youth behaviour (Kearney, 2007). Hierarchical regression and structural equation modeling were used to examine the relationship between the form of behaviour versus function and whether this was predictive of the severity of SRB (Kearney, 2007). In comparison to function, behavioural form in relation to SRB did not show any predictive value in relation to school-refusal, but an examination of the functions maintaining SRB appeared to yield improvement in predicting school-refusal (Kearney, 2007). These findings suggest that the employment of measures that provide information about the functions of school-refusal as a component of assessment may serve as a more valuable guide for directing treatment than assessment that focuses on the classification of behavioural forms. By addressing the underlying reasons that youth engage in SRB, it is more likely that interventions will address the positive and negative reinforcers that serve to maintain the behaviour, therefore increasing the chances of effective programming and positive outcomes.

CBT

Several meta-analyses and empirical studies have demonstrated the efficacy of CBT for a variety of behaviours, which, along with its short duration and goal and skill-based approach, make it a desirable component of treatment for SRB (Vinci, Coffey, & Norquist, 2015). Many elements of CBT can be effective to address the variables that may contribute to or maintain SRB. Relaxation training involves psychoeducation about the autonomic, sympathetic, and parasympathetic nervous systems, and the application of evidence-based techniques, such as controlled breathing and progressive muscle relaxation, to prompt the body’s relaxation response and thereby decrease physical symptoms of anxiety. Although relaxation training can address the physical component of anxiety, if there are negative cognitions that go unchallenged, they may continue to exacerbate uncomfortable physical sensations and lead to other negative thoughts, thus continuing a negative cycle of experience. Research has identified a link between cognitive errors and anxiety symptomatology; therefore, it is essential to also employ cognitive strategies to provide treatment that addresses both the psychological and physical aspects of anxiety (Weems, Berman, Silverman, & Saavedra, 2001). Cognitive strategies include the use of thought records to identify the thoughts, feelings, bodily sensations, and behaviour that occurs in different situations that are distressing to the individual, and methods to challenge the negative thoughts that may contribute to intense emotions and uncomfortable physical sensations. A final component of CBT is graduated exposure, which involves exposure to feared situations to reduce the level of anxiety experienced in the situation. Since individuals with anxiety disorders are more likely to hold an external locus of control, perceive the environment as hostile, have poor
self-efficacy, and expect negative results, exposure is an essential aspect of effective treatment because it provides the opportunity for individuals to challenge their anxiety and have a disconfirming experience; although they expect something negative to happen, they face the situation successfully. (Breinholst et al., 2012). This success diminishes fear and contributes to a sense of competency to handle future difficult situations. The importance of incorporating exposure is demonstrated by a study by Goldin et al. (2016) that found CBT can reduce avoidance behaviours for social anxiety disorders.

Goldin et al. (2016) assessed the differences in efficacy and durability between mindfulness-based stress reduction (MBSR) and group cognitive behavioural therapy (CBGT), enlisting 108 participants who met the DSM-IV criteria for social anxiety disorder (SAD). Participants were randomly assigned to either CBGT, MBSR, or a waitlist condition, with participants in CBGT and MBSR both receiving 12 sessions of treatment, with each session lasting 2.5 hours (Goldin et al., 2016). The CBGT condition was conducted by 2 doctoral level clinical psychologists, and the MBSR treatment was conducted by an instructor certified in MBSR with over 3 decades of experience (Goldin et al., 2016). Outcomes were assessed by the severity of social anxiety symptoms using the LSAS-SR, which measures reactions to social and performance situations using a Likert scale to obtain participant ratings of their level of fear and avoidance for each situation, and a number of factors addressed in both CBGT and MBSR that may moderate changes in anxiety levels, including: frequency and self-efficacy of cognitive appraisal, avoidance, cognitive distortions, mindfulness skills, attention focusing and shifting, and rumination (Goldin et al., 2016). Linear mixed-effects models were used to measure changes between pre- and post-conditions, showing that CBGT and MBSR resulted in significant reductions in social anxiety compared to the waitlist condition, and that CBGT and MBSR resulted in similar efficacy and durability, suggesting that they are both effective approaches for childhood anxiety (Goldin et al., 2016). However, participants in the CBGT condition exhibited greater reductions in avoidance than those in the MBSR condition (Goldin et al., 2016). This indicates that addressing avoidance and its role in anxiety may directly improve the functioning of those with anxiety disorders by reducing avoidance behaviour that can contribute to the maintenance of anxiety and impede individuals by limiting their activities (Goldin et al., 2016).

Another mechanism by which CBT may be effective for SRB is the alteration of negative cognitions. Research by Normann, Lonfeldt, Reinholdt-Dunne, and Eshbijn (2016) evaluated the effect of CBT on the negative thoughts, metacognitions, and level of anxiety for Danish children aged 7 to 12 with anxiety disorders. A total of 44 families were included in the study and received 14 weekly CBT sessions that used standard cognitive and behavioural techniques, including cognitive restructuring and graduated exposure (Normann et al., 2016). Results indicated that CBT reduced negative thoughts and beliefs, which was significantly correlated with improvement following treatment, as measured by the presence of anxiety symptoms (Normann et al., 2016). This is consistent with previous research assessing the changes associated with cognitive restructuring, indicating that there is a direct beneficial effect of cognitive techniques on negative thoughts and beliefs, as well as reducing symptoms of anxiety (Normann et al., 2016).

Although the efficacy of CBT for childhood anxiety disorders has been evaluated, randomized controlled trials are often conducted in research settings, which limits their generalizability to realistic settings, such as elementary schools (Har et al., 2013). Har et al. (2013) recruited forty children between the ages of 5 and 12 with anxiety disorders and their caregivers, who were then randomly assigned to an immediate treatment or waitlist condition.
Treatment sessions were held in a private room in the school, occurred either during or after school, and were delivered using the Building Confidence program, which was composed of various modules to teach coping skills and utilize exposure to decrease child anxiety (Har et al., 2013). Children were taught to increase their awareness of their mood and negative thoughts, use positive self-statements, and engage in exposure exercises (Har et al., 2013). After mastery of these skills, a hierarchy of feared situations was created collaboratively between children and clinicians, ranking each situation based on its level of associated distress, starting with the situation that is least distressing (Har et al., 2013). Children then moved up the hierarchy, facing each feared situation in sequence, while employing coping skills to decrease their anxiety (Har et al., 2013). Results indicated that most youth in the CBT condition responded to treatment, with 95.5% no longer meeting the criteria for an anxiety disorder at posttreatment (Har et al., 2013). This is suggestive that the implementation of CBT in real world settings has demonstrable effects on childhood anxiety, and the use of such interventions may decrease the number of children who require further mental health services.

As CBT involves exposure to feared situations, which many youth will undoubtedly be resistant of because of the discomfort they experience when anxious, the role of therapeutic alliance in treatment outcomes can be significant. Fjermestad et al. (2016) examined the relationship between therapist alliance and treatment outcomes, using a sample from a randomized controlled trial that compared individual and group CBT that included ninety-one Norwegian youth and fifteen therapists. Treatment was based on the FRIENDs manual and included components that addressed awareness and regulation of emotions, alteration of negative thoughts, and exposure to feared situations (Fjermestad et al., 2016). Therapists received supervision throughout the process, and 20% were subjected to random selection for ratings of therapeutic adherence and competence, with all selected therapists exhibiting treatment integrity (Fjermestad et al., 2016). Therapists and youth provided ratings of treatment satisfaction using the Therapist Alliance Scale for Children (TASC), both child (TASC-C) and therapist (TASC-T) versions; data was analyzed using hierarchical linear modeling (Fjermestad et al., 2016). Results indicated that early alliance, as rated by youth, predicted youth satisfaction with treatment, however no other ratings were predictive of outcomes (Fjermestad et al., 2016). Although therapist ratings of alliance were not predictive of outcomes, a study on anxiety by Marker et al., 2013 (as cited in Fjermestad et al., 2016) had contradictory results, but this may be a result of differences in assessment of alliance between the two studies. These findings suggest that therapeutic alliance may contribute to youth satisfaction with treatment, which may improve youth perception of mental health services and increase motivation to engage with community services in the future.

Despite the extensive research on the efficacy of CBT for youth anxiety, many studies have used a manualized CBT program, which is structured and does not dedicate additional time to the areas that are most problematic for the individual (Lundkvist-Houndoumadi, Thastum, & Hougaard, 2016). According to a meta-analysis by James et al. in 2013 (as cited in Lundkvist-Houndoumadi et al., 2016) about 40% of youth with anxiety disorders who have completed manualized CBT did not respond to treatment. There is evidence to suggest that parent psychopathology and symptom severity may be barriers to achieving positive outcomes (Lundkvist-Houndoumadi et al., 2016). Individualizing the delivery of CBT for non-responding youth may better address these issues than the use of manualized CBT by taking into consideration the variables that may negatively influence treatment outcomes and spending additional time on these areas, such as addressing the impact of parent mental health on children.
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and youth in individual sessions. Lundkvist-Houndoumadi et al. (2016) assessed the efficacy of an individualized CBT program for youth aged 9 to 17 with anxiety disorders who did not respond to a manualized CBT program. A total of 14 participants were included in the study, with all participants having previously completed a manualized CBT program through a randomized clinical trial (Lundkvist-Houndoumadi et al., 2016). Participants were either deemed as non-responders, based on measurements using the Clinical Global Impressions-Improvement scale (CGI-I), or had responded to the program but declined in the months following the study (Lundkvist-Houndoumadi et al., 2016). Results indicated that individualized CBT lead to significant reductions in both anxiety and functional impairment related to anxiety, with families also reporting high satisfaction with treatment (Lundkvist-Houndoumadi et al., 2016). This is suggestive that the development of an individualized treatment plan using CBT may be superior to the use of a manualized CBT program.

Limitations of the Literature

Two major limitations identified in the research on school-refusal behaviour pertain to parent involvement and individualized CBT programs. Despite evidence to suggest that parent involvement enhances treatment outcomes, there are several limitations to the research. Firstly, the parental factors identified as contributors to youth anxiety are not necessarily addressed or are poorly described, and do not provide sufficient information about areas targeted in treatment (Breinholst, Esbjorn, Reinholt-Dunne, & Stallard, 2012). Breinholst et al. (2012) note that randomized controlled trials often fail to provide a theoretical basis for how involving parents influences child behaviour, and although one study described the method to achieve this, parent skill and engagement was a limitation. Lastly, outcome measures are often focused on youth anxiety symptoms but neglect to assess changes in parents’ thoughts and behaviours, which makes it impossible to decipher whether a lack of results was due to a failure to revise treatment targets or because parent involvement simply did not make a significant difference (Breinholst et al., 2012). Additionally, a study by Bodden et al. in 2008 (as cited in Breinholst et al., 2012) incorporated parent involvement in group CBT for youth with anxiety and found that treatment focused on the child alone was more effective; only for children whose parents were also anxious were results enhanced by parent involvement.

Another limitation of the literature previously mentioned is that many studies use manualized CBT programs. Although this approach provides structure and has demonstrated efficacy, according to the literature there are many individuals who fail to benefit from this method of treatment delivery. However, there is limited research on the efficacy of individualized CBT. As presented by Lundkvist-Houndoumadi et al. in 2016, individualized CBT programs may provide greater benefit to individuals by targeting the most salient variables that contribute to their mental health symptoms. Individualizing programs may increase child and youth engagement during sessions because the material presented has direct relevance to the individual and their experience, increasing the likelihood that the intervention will be successful.

Conclusion

A review of the literature on school-refusal, mental health, and treatment approaches for SRB and anxiety, provides sufficient evidence to support that the use of a collaborative approach, a functional model, and cognitive and behavioural techniques, are all effective components of intervention for SRB. Interdisciplinary care and parental involvement may enhance treatment outcomes by allowing the incorporation of information from multiple sources to be utilized in treatment programming. The research indicates that the functional assessment of
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SRB is an effective method of evaluating the factors that contribute to and maintain SRB and gives direction for the development of interventions that address these variables, which increases the likelihood of successful outcomes. CBT has been demonstrated to be effective for mental health symptoms in several populations, with changes seen in negative cognitions and avoidance of feared situations. As many youth engage in SRB to avoid distress related to school, addressing the physical sensations and negative thoughts experienced in relation to school, in combination with exposure to school and school-related stimuli, would decrease the amount of distressed experienced at school and increase the likelihood of regular school attendance. Although there are gaps in the literature on parent involvement, there is evidence to suggest that parent psychoeducation and training can enhance outcomes for school-refusing youth. Despite this limitation, an analysis of the literature supports the use of these approaches to decrease mental health symptoms and increase school attendance. This indicates that the proposed study, the School Attendance Project, should be an effective intervention to reduce the severity of mental health symptoms and increase school attendance among selected participants.
Participants

This study included two youth participants: a 14-year-old male (participant 1), a 12-year-old female (participant 2). Participant 1 lived with his mother, step-father, and younger sister, and had a history of family trauma and attendance issues beginning shortly after his mother left an abusive relationship. Participant 1 was bullied at both his current and past schools, with peers making negative comments about his weight. The participant’s attendance counsellor reported that his attendance issues appeared to be related to his concern for his mother, who was pregnant at the time that the study began, with the participant corroborating this with statements during individual sessions about concerns over his mother’s delivery. The participant’s attendance counsellor also reported that there were accommodations in place for participant 1 to arrive to school later and leave early to avoid the rush of other students in the hall and on the city bus, as he expressed that this contributed to his nonattendance. Despite these accommodations, prior to the study participant 1 often missed school, instead returning home after dropping his sister off at school in the morning. His mother reported that when the participant was sad or angry he made statements indicating suicidal intent, but also reported that she did not believe that he would follow through and rather used this behaviour to obtain her undivided attention. Participant 2 lived with her mother, father, sister, and foster sister, and had a diagnosis of anxiety and history of chronic school refusal behaviour. The participant’s mother and attendance counsellor both reported that she had missed a considerable number of school days in the past two years, often citing physical ailments such as headaches or stomach aches as reasons for nonattendance. The participant’s mother also reported that she was hesitant to express any thoughts or feelings associated with negative emotions, such as anxiety, anger, or sadness, which made it difficult to understand what the participant was experiencing and identify areas to target. In addition, the mother of participant 2 was also included in the study, as she was in regular attendance at a weekly parent group associated with the study. To identify potential participants that would benefit from the study, school attendance counsellors referred students who were currently engaging in school refusal behaviour and had missed a significant amount of school as a result. Students and their parents were provided with information about the study by the researchers and were invited to participate. Participants were invited to participate if they engaged in school refusal behaviour, presented with mental health symptoms, and were deemed suitable for the study based on a collaborative decision by clinicians, attendance counsellors, and undergraduate students. Participants were not included if they were located 20 km or further outside of the city, or if they posed a risk to themselves or others due to self-injurious or aggressive behaviour.

Informed consent procedures. Informed consent was obtained through intake interviews with parents and students. Parents were provided with a document containing detailed information about the study and contact information for the researchers, their supervisors, and relevant ethics boards. The study was explained by the researcher and parents were given time to discuss the decision to participate with their children and other family members prior to signing the consent form (Appendix A). As the student participants were under the age of 16, parents were required to provide consent on their behalf, but verbal assent was also obtained from the participants through a brief conversation to introduce the project and ask if they were interested in participating. Parents were also given a document with information about the parent psychoeducation group, and consent was obtained using a consent form (Appendix B). Consent forms for this study will be stored in a locked filing cabinet in the research department at St. Lawrence College for 10 years following the participants’ 18th birthdays.
Prior to implementation, this study was approved by the St. Lawrence College Research Ethics Board and the Health Sciences and Affiliated Teaching Hospitals Research Ethics Board.

Design

This study used a single-subject AB design, with baseline and intervention measures of school attendance, and pre- and post-measures of mental health symptoms. Data were analyzed using mean, standard deviation, and changes in total scores between pre- and post-assessment. Data were examined through visual analysis of line and bar graphs. The intervention was implemented by the researcher under the supervision of the agency supervisor and two attendance counsellors. Assessments and session notes were kept in a file at the hospital and recorded in the patient care system.

Independent variables. The independent variables in this study were individual CBT programs based on the functional model of assessment for school-refusal and the parent psychoeducation group. The functional model was used to assess the function of participants’ school refusal behaviour and serve as a guide to select appropriate cognitive and behavioural techniques based on the identified function(s). The parent group provided information about school-refusal, mental health, and cognitive and behavioural techniques to increase parents’ ability to support their child with mental health symptoms and school attendance.

Dependent variables. The dependent variables in this study were school attendance and mental health symptoms. A baseline of school attendance was obtained through attendance records at the participants’ schools, and pre- and post-measures of mental health symptoms were taken using the Beck Youth Inventory – Second Edition (BYI-II) and Self-Compassion Scale (SCS). The BYI-II was used to determine if the intervention resulted in a decrease on the anxiety and depression subscales within the measure, and the SCS was used to evaluate changes in participants’ self-judgement and self-compassion. School attendance was defined as a participant’s physical presence in the school building, whether the participant arrived late or left school early. There were a few reasons for this criterion: participant 1 had accommodations to arrive at school late and leave early, and participant 2 only had difficulty getting to school and would stay for the entire day once there. Participant 1 also had accommodations to work at a desk by an office area in the school instead of attending his regular first period class.

Setting and Apparatus

Participant 1 and 2. Individual sessions occurred at the participants’ schools, an elementary school and a high school, in a private room during school hours and in participant 2’s home. One intake interview occurred at the hospital, and the other at the participant’s home. Session materials were adapted from an unpublished manuscript for manualized CBT and self-compassion training and included infographics, CBT worksheets, online resources for coping strategies, paper, markers, and binders to store materials for individual sessions (Blaney, Pike, & McIvor, 2016).

Parent participant. The parent group was held in a group room at the hospital after work hours, with a total of three parents attending group sessions. Two of the parents in attendance were parents of children in the study. Sessions were presented using PowerPoint slide shows and handouts. Materials included PowerPoint slideshows, a laptop, a projector, duo tangs with handouts and hard copies of PowerPoint slides for each session, online resources for coping strategies, and feedback questionnaires.
MEASURES

School Refusal Assessment Scale-Revised (SRAS-R). The SRAS-R child and parent versions, (C) and (P), included as Appendices C and D, were used during the intake process to identify the functional variables that maintained the participants’ school-refusal behaviour. These assessments that were designed to assess the function of school refusal behaviour, with four categories to represent four potential functions: avoidance of general distress related to school or school-related stimuli, escape from aversive social or performance situations, access to attention, and access to tangible items (Kearney, 2008). The scales are meant to be used in combination when possible to obtain multiple perspectives on the behaviour (Kearney, 2008). The SRAS-R consists of 24 questions related to school attendance, distress associated with school, and consequences for nonattendance, and parents and children are asked to select the response they feel is most representative for each question by providing a rating on a Likert scale ranging from 0 (never) to 6 (always) (Kearney, 2008). Research indicates that this assessment has good discriminant and construct validity, further adding to support for the use of the functional model (Kearney, 2006).

Beck Youth Inventory—Second Edition (BYI-II). The BYI-II was used as a pre- and post-measure of mental health symptoms to determine if the intervention demonstrated a change in any of the subscales contained within the measure, notably anxiety and depression, as these would be the most indicative of mental health symptoms to target in treatment. The BYI-II is composed of five subscales that provide scores corresponding to self-concept, depression, anxiety, anger, and disruptive behaviour, with each subscale containing 20 statements relating to the category (Beck, Beck, Jolly, & Steer, 2005). Test-takers are instructed to provide one answer for each statement, using a Likert scale that ranges from 0 (never) to 3 (always), that best describes their experience in the past two weeks (Beck et al., 2005). Raw scores are then translated into t scores, with scores of 60 and above indicating clinical significance (Beck et al., 2005). Research indicates that the BYI-II has good reliability and internal consistency, demonstrating little gender difference, as well as convergent and divergent validity, which is shown through correlations among subscales and comparison to other established assessment measures that evaluate similar notions (Beck et al., 2005). This measure was not included as an appendix due to copyright law.

Self-Compassion Scale (SCS). The SCS (Appendix E) was used as a pre- and post-measure of participants’ attitudes and behaviours toward themselves when experiencing psychological or emotional pain. This was selected as an appropriate measure due to its ability to provide scores associated with concepts covered in each of its subscales: self-kindness, self-judgment, common humanity, isolation, mindfulness, and over-identification (Neff, 2003). The SCS is composed of 26 statements associated with each of the subscales, and test-takers are instructed to provide a rating for each using a Likert scale ranging from 1 (almost never) to 5 (almost always). Scores are then totalled for each subscale and an average is calculated for each; scores for each subscale are then totalled and an overall mean is calculated (Neff, 2003). However, prior to calculation of a total mean, the scores for self-judgement, isolation, and over-identification are reversed, as recommended by Lopez et al. (2015). Although there is not a guide to scoring for this scale, as the overall score is related to an individual’s level of self-compassion, it is possible to use the scale as a tool to provide comparisons of pre- and post-measures to identify whether intervention had a positive effect on any of the subscale scores or total score for self-compassion. The SCS demonstrates good reliability and validity, as evidenced through studies reported by Neff (2015).
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Procedure

Participants 1 and 2 were assessed to determine the function of their school refusal behaviour, with interventions developed individually based on the results of the functional assessment. Cognitive and behavioural techniques were adapted from an unpublished manuscript for manualized CBT and self-compassion training (Blaney, Pike, & McIvor, 2016). Sessions were delivered by the researcher under the supervision of clinicians and attendance counsellors. Sessions for participant 1 occurred on a weekly basis and lasted for 45 minutes. Sessions for participant 2 varied due to her absences from school and were dependent upon the availability of the attendance counsellor and supervising psychologist to attend home visits. Due to guidelines for undergraduate students working under supervising clinicians, home visits required the presence of either a clinician or attendance counsellor. Sessions with the parent of participant 2 occurred on a weekly basis for 2 hours during the parent psychoeducation group, aside from the home visits conducted with participant 2. Tables providing a breakdown of content covered in sessions for each participant are included in appendices; see Appendix F for participant 1, Appendix G for participant 2, and Appendix H for the parent participant.

Participant 1. All sessions with participant 1 were delivered by the researcher and occurred at the participant’s school in a private room or office during school hours, aside from the intake interview with the participant’s mother, which occurred at the hospital in a private room.

Intake interview. The first half of the intake interview was conducted by the researcher with the participant’s mother and attendance counsellor, with the attendance counsellor leaving the room halfway through the session. The participant’s mother answered questions about her son’s background and was provided with information about the study and parent group.

Session one. The first session was conducted with the participant and his attendance counsellor, as she had already established rapport with the participants, therefore her presence was likely to increase his level of comfort during the meeting. This session focused on informed consent and goal-setting.

Session two. The second session involved the completion of assessments, an introduction to CBT and relaxation exercises, and psychoeducation about anxiety, to introduce the participant to the material that would be introduced in following sessions.

Session three. The third session covered graded task assignment and the identification of different scenarios that cause anxiety and anticipated anxiety ratings to create a plan for the participant to begin to take the bus to school to arrive at the start of the school day.

Session four. In the fourth session, thought records were introduced so that the participant could begin to identify the thoughts, emotions, and bodily sensations associated with distressing or uncomfortable situations. Progressive muscle relaxation was also conducted in session with the participant to provide him with another coping strategy to use when anxious.

Session five. This session focused on cognitive distortions and thought challenges, to provide the participant with more insight into the relationship between negative thoughts and emotions, physical sensations, and behaviour, and provide him with strategies to challenge negative thoughts that contain thinking errors.

Session six. As the participant was resistant to working on steps identified toward taking the bus at an earlier time to school, the last session consisted of a check-in and discussion for a plan for support moving forward.

Participant 2
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**Intake interview.** The intake interview was conducted at the participant’s home with the researcher, the participant, her mother, father, and attendance counsellor. The participant’s history of school refusal behaviour and mental health symptoms was discussed, and parents were provided with information about the study and parent group. The participant’s parents signed a consent form for her to participate in the study and the participant provided verbal assent.

**Session 1.** The first session was delivered by the researcher and involved an introduction to the CBT model, relaxation exercises, and psychoeducation about anxiety. No assessments were completed due to the session being interrupted. However, a detailed background of the participant’s history was taken during the intake interview, and information was also gathered from her attendance counsellor and medical file.

**Home visit.** The participant was not in attendance at school, which created a barrier to service delivery. Therefore, a home visit was scheduled with the researcher, supervising clinician, the participant, and her mother to collaboratively create a plan for the participant’s return to school. Although the participant did not verbally answer many questions related to school, the clinician reflected her understanding of the participant’s body language as a way to encourage her to express her feelings about school and why it is difficult to attend. The participant identified slight difficulty with math and science, and a plan was made for the researcher to meet the participant in the morning at the school the following week. Despite this plan, the participant was not in attendance at school on Monday or Tuesday, and as it was the final week of the study, the clinician scheduled a home visit with the participant and her mother to create a plan for continued support following the study.

**Collaborative Approach**

Meetings amongst attendance counsellors, mental health professionals, faculty, and students occurred monthly throughout the study. These meetings allowed professionals to share information about participants, discuss potential areas to target in interventions, and develop plans for future support after the end of the study.

**Parent Group**

The parent group was implemented by the researcher and two other undergraduate students and was supervised by one of the clinicians at the hospital who had experience working with children and their parents in the school setting.

**Session 1.** The first session covered school refusal, the four functions of school refusal behaviour, and the CBT model. The objective of this session was to introduce group members to one another and basic concepts about school refusal and mental health that would be further discussed in future sessions, as well as obtain a pre-measure of parents’ sense of confidence in supporting their child with mental health symptoms and school attendance.

**Session 2.** The purpose of this session was to provide parents with more information about mental health and strategies that could be implemented immediately to reduce intense emotions and gather more information about why it is difficult for their child to attend school.

**Session 3.** This session covered stress, self-regulation, and behavioural strategies. Strategies to cope with stress and effectively self-regulate were discussed, and parents were provided with several behavioural strategies to support their child with mental health symptoms and school attendance.

**Session 4.** Parents were encouraged to share their experiences with supports available through the schools and behavioural strategies previously tried, with discussion surrounding parent perceptions of why the strategy was effective or unsuccessful. The presenters discussed learning challenges, IEPs, and advocacy.
Session 5. Information was collected about what group members did and did not enjoy about the group, what they learned, and how confident they felt in supporting their child and getting their child to school on a regular basis. Major concepts covered in previous group sessions were reviewed, and parents were encouraged to discuss takeaways from the group and their plans moving forward.

The two parents of participants in the study were also involved with intake interviews and home visits and were regularly contacted throughout the study by the researchers to provide support and discuss participant progress.
Chapter IV: Results

This study aimed to identify the functional variables maintaining school refusal behaviour using the School Refusal Assessment Scale – Revised (SRAS-R), increase school attendance, and reduce mental health symptomatology, as identified by scores on the Self-Compassion Scale (SCS) and the anxiety and depression subscales contained within the Beck Youth Inventories – Second Edition (BYI-II). Results are presented in order of participant.

Participant 1

**Functional assessment.** Participant 1 completed the School Refusal Assessment Scale - Revised (SRAS-R) on November 22, 2017. The participant’s mother did not complete the scale. Scores for the SRAS-R were calculated using guidelines provided by Kearney (2008). First, a total score was computed for responses provided on questions related to each of the four potential functions. Each total score was then divided by the number of questions on the scale pertaining to each function to obtain a mean score. Mean scores were then compared, with the highest score indicating the primary behavioural function. If scores fell within .5 of one another, they were considered equivalent.

![Subscale mean scores on SRAS-R for participant 1.](image)

The results of the School Refusal Assessment Scale-Revised (SRAS-R), presented in Figure 1 and Appendix I, indicated that the primary function of the participant’s school refusal behaviour was attention from significant others. The mean score of 3.33 was significantly higher than the other three mean scores, indicating that the primary function of the participant’s school refusal behaviour was attention. Scoring information provided by Kearney (2008) states that if scores fall within .5 of one another that they are considered equivalent. The three other functions fell within .5 of one another and therefore were identified as secondary functions of the participant’s school refusal behaviour.

**Outcome measures.** Pre-intervention measures of mental health symptomatology were taken using the Beck Youth Inventory-Second Edition (BYI-II) and the Self-Compassion Scale (SCS). Figure 2 presents the pre-intervention scores for BYI-II subscale items, and figure 3
presents pre-intervention scores for subscales within the SCS. The pre-intervention scores for the BYI-II and SCS subscales for participant 1 are presented in Appendix J.

**Beck Youth Inventories – Second edition.** Participant 1 obtained a T score of 41 on the BDSCI-Y subscale of the BYI-II, self-concept, which is lower than average according to Beck, Beck, Jolly, and Steer (2005). The T score for the BAI, anxiety, was 56, indicating a mild elevation, but not of clinical significance (Beck et al., 2005). The participant’s T scores for the BDI (depression), BANI (anger), and BDBI (disruptive behaviour), were 39, 41, and 44 respectively, which all fall within the average range.

**Self-compassion scale.** Scores for the SCS were calculated using an online resource by Dr. Kristin Neff, which also calculates an overall self-compassion score based on inputted data (Neff, 2018). As recommended by Lopez et al. (2015) scores for the negative subscales, self-judgement, isolation, and over-identification were reverse scored, as higher scores on these are reflective of lower self-compassion (Neff, 2018). The overall self-compassion score for participant 1 was 3.39, which indicates moderate self-compassion, as it falls between 2.5 and 3.5 (Neff, 2018).

![Figure 2](image-url)  
*Figure 2. Pre-intervention subscale T scores on the BYI-II for participant 1.*
Attendance data. Attendance data from the participant’s school was collected and reviewed to compare the attendance of participant 1 from baseline to intervention. The attendance counsellor reported that participant 1 had a longstanding history of irregular school attendance, which began 3 years ago after his mother left an abusive relationship. The attendance counsellor also reported that despite accommodations made to his schedule, participant 1 would often return home after dropping his sister off at school in the morning, and if he did attend school, would leave early. Both the attendance counsellor and school counsellor reported that participant 1 had access to support within the school but would often contact his mother via text message for assistance while in class rather than accessing support at school.

See Appendix K for raw baseline and intervention data and calculations. During baseline, participant 1 attended 43.00% of classes, which increased to 47.00% in the intervention phase. This indicates an increase of 4.00% in school attendance during the 6 week intervention. Figure 4 presents the baseline and intervention data for the weekly percentage of classes attended for participant 1.

Visual analysis. The participant’s attendance was stable during baseline, with 88.00% of data points falling within 25% of the median, however the intervention data was highly variable, with only 33.00% of data points falling within this range (Gast & Ledford, 2014). Calculations are provided in Appendix K. The participant’s attendance was highly variable during baseline and intervention. From the beginning of baseline in September to the middle of October data remained at a moderate level. The data peaked in baseline the week of October 23, 2017 at 80.00% of classes attended but dropped again the following week to 48.00%. Attendance peaked again upon implementation of the intervention, rising to 76.00% for the first week and continued to fluctuate until the end of intervention. Trend lines for both baseline and intervention phases are shown in Appendix K, showing a slightly increasing trend during baseline and a moderately
decreasing trend in the intervention phase. This indicates that despite the increase in classes attended between phases, the participant’s attendance began to decrease after implementation of the intervention. Following recommendations from Ma (2006), the Percentage of Data Points Exceeding the Median (PEM) was calculated for graphed data. The PEM for participant 1 was 66.66%, which, according to Scruggs and Mastropieri (1998), means that the effectiveness of the intervention is considered questionable, as the score lies between 50% and 69%.

![Graph](image)

**Figure 4.** Weekly attendance during baseline and intervention for participant 1.

**Participant 2**

**Functional assessment.** The parents of participant 2 completed the School Refusal Assessment Scale – Revised (SRAS-R) on November 30, 2017. This measure was not completed by the participant. Scores for the SRAS-R were calculated as described above for participant 1. Since both parents completed the measure, an additional step was taken to calculate an overall mean score for each functional variable on the scale. Mean scores were calculated individually for each assessment, and then the mean scores were added to one another and divided by two to obtain an overall mean score for each function identified on the scale. See Appendix L for mean scores for each potential function, overall mean scores, and relative rankings.

The results of the SRAS-R, presented in Figure 5, identified avoidance as the primary function of the participant’s school refusal behaviour. Parent responses were consistent with one another and with information obtained from the attendance counsellor and clinical files. The mean score for avoidance was significantly higher than the other scores, indicating that this was the primary function. The scores for the other three functions were close and considered secondary and equivalent, as they all fell within .5 of one another (Kearney, 2008).
Clinical file review. As participant 2 was often absent from school and access to the home was limited, the BYI-II was not completed. The SCS was not completed for this participant due to her age and developmental level. Despite this limitation, the participant’s clinical files from previous visits and assessments were reviewed using the patient care system. Participant 2 was previously assessed at the hospital and was diagnosed with anxiety. Information in clinical notes indicated that the participant presented as shy and reluctant to speak, with mom reporting that she often experienced somatic symptoms, including stomach pain preceding school attendance, and had difficulty with self-advocating at school.

Attendance data. Attendance records were obtained from the participant’s school and reviewed. The attendance counsellor reported that the participant’s attendance difficulties began the previous year, which was attributed to learning difficulties, anxiety, and the participant being bullied at school. The attendance counsellor reported that numerous supports had been organized within the school to accommodate participant 2, including permission to leave class at any time to access a quiet room in the school. Despite these supports, the participant’s mother reported that participant 2 had difficulty advocating for herself and accessing these supports when she felt she needed them. This indicated that despite organizational support, the participant still had difficulty attending school.

Baseline and intervention data and calculations are presented in Appendix M. During baseline participant 2 attended 47.00% of school days, which decreased in the intervention phase to 24.00%. This represented a difference of -23.00%, indicating that the participant’s attendance considerably decreased after implementation of the intervention. Figure 6 provides a visual representation of the weekly attendance data in baseline and intervention for participant 2.

Visual analysis. During the baseline phase the data were stable, with 80.00% of data points falling within 25% of the median, and data in the intervention phase were highly variable, with only 20.00% of data points in this range (Gast & Ledford, 2014). Calculations for stability are provided in Appendix M. Data ranged from low to high levels in baseline, with the lowest data point at 28.00% and the highest at 75%. However, aside from these two outliers most data points were at moderate levels. Trend lines, presented in Appendix E, show a slightly decreasing
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trend during the baseline phase, and a moderately decreasing trend after intervention implementation, with little change between phases. The PEM score for participant 2 was 20.00%, indicating that the intervention was ineffective, as the score fell below 50% (Scruggs & Mastropieri, 1998).

![Graph showing weekly attendance during baseline and intervention for participant 2.](image)

*Figure 6. Weekly attendance during baseline and intervention for participant 2.*

**Parent Feedback Questionnaire**

**Pre- and post-measures.** Parents that attended the group completed a pre- and post-measure in the form of feedback questionnaires, provided in Appendices N and O. On the initial questionnaire all parents indicated that they had previously attended a parent group, and overall identified that they would like to learn coping strategies to deal with stress and ways to approach discussing mental health with their children. Parents identified that after completion of the group they would like to be able to openly discuss mental health with their children, successfully get their child to school on a regular basis, and more effectively reduce their own stress. Parents also provided ratings of their confidence in getting their child to school regularly and calming their child down when they are worried or anxious. See Appendix P for pre-, post-, and difference-test scores for parent ratings. Overall, there appeared to be no difference between parent ratings of confidence before and after completing the group, with three of four difference scores at 0.00. The fourth difference score was -1.00, which was for the mother of participant 2. This indicated that her confidence in getting her child to school on a regular basis decreased from pre-test to post-test.
Chapter V: Discussion

Summary

This project aimed to increase school attendance and decrease the severity of mental health symptoms for children and youth with school refusal behaviour by using a functional model, cognitive and behavioural techniques, and a collaborative approach. Individualized interventions were developed based on the results from assessments and information provided by attendance counsellors, parents, and participants. Interventions were then implemented in the school and home settings.

Participant 1’s attendance was variable throughout baseline and intervention but increased slightly between phases. Functional assessment results indicated that the primary function of the participant’s behaviour was attention. Therefore, attention from the researcher was incorporated into the intervention during individual sessions in the form of conversation about topics of interest to the participant. To increase engagement during individual sessions participant 1 was asked open-ended questions about games and activities that he had previously displayed significant interest in talking about. Information provided by the attendance counsellor, school counsellor, and the participant’s mother indicated that most concerns the participant expressed were related to his mother’s wellbeing. The participant also reported that his mother had experienced complications when his younger sister was born, which made him concerned that something might go wrong again with this delivery. As the participant had previously witnessed violence toward his mother, and a complicated pregnancy required for her to stay home on bedrest, it is possible that this situation evoked feelings of concern or helplessness that were like past traumas. This may have increased the severity of the participants’ mental health symptoms and negatively impacted his school attendance. The participant reported that his mother had experienced complications when his younger sister was born and that he was concerned something might go wrong again with this delivery. After the baby arrived, the participant reported that he would likely be absent from school because his step-father had to go back to work, and his mother did not have any family or friends nearby to help her with the baby throughout the day. These results suggest that the participant’s history of trauma, his mother’s pregnancy, and lack of family support may have been uncontrolled variables that influenced the participant’s school attendance and impacted the efficacy of the intervention. In addition, there were functions other than attention identified on the SRAS-R as maintaining the participant’s school refusal behaviour that were not targeted in intervention and may have influenced the efficacy of the treatment program.

Participant 2 had a history of chronic school refusal behaviour, with her mother reporting that the participant’s older sister also displayed a history of sporadic attendance. The participant had been diagnosed with anxiety, and the participant’s mother reported that she had also been diagnosed with anxiety and depression. Functional assessment results indicated that the function of the participant’s school refusal behaviour was avoidance, which was consistent with parental and clinical reports. Therefore, psychoeducation about anxiety and identification of the physical sensations experienced when anxious were reviewed with the participant. The attendance counsellor and participant’s mother reported that the participant’s attendance usually starts high at the beginning of the school year, but steadily declines as the year progresses. The participant’s attendance decreased during intervention, which may have been influenced by this behavioural pattern. It is also possible that sessions with the researcher had not been sufficiently paired with reinforcement, and therefore attending school or participating in individual sessions was not reinforcing enough to compete with the reinforcement the participant obtained by avoiding these
situations and staying at home. Participant 2 would benefit from a program that was based on functional assessment results and was implemented in both the home and school settings. This would ensure that the variables contributing to her school refusal behaviour were addressed and that there was consistency in treatment delivery across people and settings.

The feedback provided by parents who attended the psychoeducational group indicated that although they learned strategies to cope with stress, their confidence in supporting their child and getting their child to school on a regular basis did not change after completion of the group. The score for parent confidence in getting their child to school decreased for the mother of participant 2 by the end of the parent group. These results suggest that although parents reported that they enjoyed the group, it did not significantly change their levels of confidence in the above areas.

It was hypothesized that the use of a functional model and CBT in conjunction with a collaborative approach involving parents and mental health and school-based professionals would increase school attendance and decrease mental health symptoms for selected participants. The results from this study do not support this hypothesis. However, uncontrolled variables coupled with a small sample size may have impacted the efficacy of the intervention.

**Connection to literature review.** The results of the study indicate that, despite nonsignificant results, the incorporation of undergraduate students into the collaborative team allowed for the completion of assessments that may have otherwise been delayed. This is consistent with findings from Simons et al. (2012), that indicated practicum and internship programs are beneficial to all involved; the completion of assessments, gathering of information, and case formulation during this study will serve to aid future treatment efforts with the involved participants.

Despite the use of a functional model for school refusal, the results for both participants were insignificant. Research by Kearney (2007) indicates that functional assessment results can guide treatment by identifying salient variables contributing to school-refusal behaviour, and although attention was incorporated into the intervention for participant 1, the results from this study conflict with these findings. This indicates that the functional variables were not sufficiently targeted in individual interventions, and therefore may have continued to impact the participants’ behaviour, which serves to highlight the importance of addressing these variables to improve treatment outcomes. As it is likely that children and youth engage in school-refusal behaviour for more than one function, as evidenced by results from the SRAS-R for both participants, it is also essential that all these functions are appropriately addressed in individual programs.

Regarding the use CBT, it is unclear whether there was an impact on participants’ mental health symptoms. As previously discussed, Goldin et al. (2016) compared group CBT and mindfulness-based stress reduction (MBSR) with results signifying that both were effective treatments. These treatments both involve a cognitive restructuring component, which addresses the negative cognitions that contribute to physical symptoms and avoidance behaviours. As this study lacked objective data for both participants, it is impossible to know whether the interventions positively impacted mental health symptoms. This discrepancy could also be attributable to the limited number of individual sessions, especially for participant 2, insufficient reinforcement during individual sessions, and environmental variables not targeted during intervention, such as the contingencies in place in the home environment for school attendance and nonattendance for both participants.
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Contrary to research by Lebowitz, Omer, Hermes, and Scahill (2014), who found that more than half of children whose parents attended a workshop showed improvement, the addition of a parent workshop did not appear to enhance the efficacy of the intervention or improve parents’ ratings of confidence. However, this is aligned with results from Bodden et al. in 2008 (as cited in Breinholst et al., 2012) that suggested intervention efforts were more successful when focused on the child alone without parent involvement; only children whose parents also experienced anxiety benefitted from parent involvement in treatment. In this vein, the results from the current study are in opposition to these findings, as the mother of participant 2 self-identified with anxiety and attended the parent workshop. However, parent mental health was not targeted in the parent group. It is possible that a parent group designed to address parent psychopathology would be more effective for children whose parents also display mental health concerns.

Strengths

A major strength of this project was the collaborative involvement of multiple mental health and school-based professionals, notably school attendance counsellors. The attendance counsellors already had an intimate knowledge of the participants’ history and current situation and had developed a rapport with participants and their families, and therefore served as an invaluable source of information and guidance for intervention development and implementation. Another strength was that participants received services through the hospital during the study, which allowed for continued access to services after the completion of the study and ensured that information gathered during the study would be available to hospital clinicians and staff. This also assured that adequate follow-up would be completed and that the participants and their families would continue to be supported.

An additional strength of this study was the use of the functional model to assess the function of the participants’ school refusal behaviour. Although the interventions described were not implemented as intended, the information gathered from the completed assessments will be valuable for those working with participants in the future.

Limitations

The limited number of sessions and lack of objective data for both participants, notably participant 2, was a significant limitation of this study. This prevented the comparison of scores from baseline and intervention to determine whether the participants’ mental health symptoms had decreased. Although participant 2 had previously been diagnosed with anxiety, the completion of a recent assessment using a validated instrument would have ensured that the intervention was addressing relevant targets rather than relying solely on information obtained through a review of the participant’s clinical file and an intake interview conducted with the participant’s parents and attendance counsellor. Participant 1 completed the BYI-II during baseline but was absent from school for the week following the study, which prevented the completion of a post-assessment. These results would have shown if there were any changes from the baseline measurement in the participant’s self-concept or anxiety scores.

The very nature of school refusal behaviour can make it difficult to implement an intervention; if sessions are to occur in the school environment but the participant is frequently absent, this can be a major limitation to effect positive change. There are also numerous variables that can influence school attendance, further complicating treatment planning for children and youth who engage in school-refusal. Mental health issues can exacerbate school refusal behaviour and repeated avoidance can ultimately lead to increased anxiety, creating a
INCREASING SCHOOL ATTENDANCE

cycle that can be difficult to break, as it can be very uncomfortable for individuals to face situations that are associated with aversive thoughts, feelings, and physical sensations. If this behaviour is frequently accommodated by others in the environment, it is more likely that it will be resistant to intervention efforts, or that such efforts may be undermined by the accommodation of significant others. Participant 1 reported that he did not perceive his attendance as problematic and did not see a need to attend the entire school day, as he had accommodations to arrive late and leave early, indicating that the role of accommodation may also contribute to participant motivation and resistance to change.

Multilevel Challenges to Service Implementation

Client level. It is common for children and youth to attribute physical symptoms associated with anxiety or depression to a physical cause and may not identify with terminology that describes the symptoms they experience as anxiety. Participant 1 did not identify with statements that used the term anxiety, but if this was substituted for the term worry, he rated the statements as accurately describing his experience. Participant 2 had been diagnosed with anxiety, but it was unknown whether she felt that the diagnosis was accurate of her experience. Participant 2 freely spoke about her interests with her parents and the researcher but was reluctant to express her negative emotions, including sadness and anger, to anyone, including her mother. However, her mother reported that she frequently cited physical ailments as reasons to miss school, such as headaches, stomach aches, and shoulder or back pain. This indicates that participant 2 was not necessarily aware of the connection between her experience of anxiety and the physical sensations associated with it, instead reporting that she believed she was sick or that the symptoms were related to a physical rather than psychological cause.

Program level. There were inconsistencies between the intended implementation of the interventions and their delivery, which likely impacted the fidelity of the study. Factors that may have impeded treatment fidelity include the number of sessions delivered and inconsistency in the number of sessions per week. There were a limited number of sessions for both participants, especially participant 2, which were insufficient to create a significant change in school attendance. Sessions for participant 1 were delivered on different days of the week and the number of sessions each week varied between 1 and 2, both of which may have decreased the efficacy of the intervention.

Organizational level. As a student working under the supervision of clinicians and attendance counsellors, there are limitations to meeting with clients both inside and outside of school or clinical settings. Interventions implemented in the school setting are limited to school hours, which only constitute part of the day. Participant 1 had academic accommodations to arrive to school late and leave early, which further limited the time frame in which to conduct sessions. These accommodations also may have influenced the participant’s perception of his school attendance; he expressed that he did not see his attendance as problematic because his absences were permitted under the accommodations. Participant 2 frequently missed school and her mother reported that she did not often leave the house, which made it difficult to conduct assessment and implement intervention when supervisors were not available to conduct home visits with the researcher.

Societal level. A significant part of adolescent development is establishing an identity outside of the family and becoming more connected to peers. Participant 1 was overweight and had reported multiple incidents of bullying to his mother, the school counsellor, and his attendance counsellor, and almost all reports included hurtful statements about his weight. This undoubtedly increased the participant’s sense of social isolation and lowered his motivation to
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attend school. Participant 2 had limited opportunities to develop peer relationships due to her absences from school and unwillingness to spend time with peers anywhere other than her home. This likely contributed to her sense of isolation and increased her social anxiety while at school. The desire to be accepted and perceived positively by others is especially important for children and youth, as this shapes the way that they view themselves and the way that they interact with others. Therefore, the stigma that accompanies mental health concerns can make it difficult for children and youth who experience them to express their thoughts and feelings with others due to fear of judgement and social rejection.

Contributions of the Study

This study validated the strength of a collaborative approach, which facilitated the development of individualized interventions by providing access to multiple sources of information about participants and different treatment perspectives. This allowed for the consideration of both empirical research and clinical judgement on the efficacy of different treatment strategies for children and youth with school refusal behaviour opposed to relying on one source of expertise. Since participants received services through the hospital during the study, this allowed for them to continue accessing services after the study was complete, which ensured that further support was available if needed. The collection of data on the function of participants’ behaviour in this study was beneficial, as knowledge of the variables that maintain school refusal behaviour will be valuable for school-based professionals and can be used by clinicians to inform treatment planning.

Recommendations for Future Research

Limitations of this study highlight areas of consideration for future research on school refusal behaviour and mental health for children and youth. Firstly, emphasis should be placed on the contingencies in the child or youth’s environment, as identified during functional assessment, as these are the key to effective interventions for school refusal behaviour. For children or youth who access to attention or tangibles is identified as a primary function, it is essential to ensure that this reinforcement is available in the school environment, and that the person working one-on-one with the individual has been adequately paired with reinforcement. This can prevent treatment sessions from developing an aversive association, due to the discomfort that individuals may experience when talking about and challenging their anxiety. Secondly, objective data should be collected on variables that may influence school attendance, such as mental health symptoms. This would facilitate the development of interventions by identifying areas to target in treatment and serve to demonstrate whether the intervention influences any changes in these variables. Future research should ensure that there is an adequate time frame within which to deliver treatment, as this will increase the likelihood of positive outcomes. A minimum of 8 sessions is recommended to provide adequate time to complete assessments and develop a rapport with participants prior to treatment implementation. Finally, the current study was considerably limited due to the inclusion of only two participants, therefore future research in this area should focus on replication of this study using a larger sample size. Replication should include the use of all elements described in this study’s methodology: the functional model for school refusal behaviour, CBT, and a collaborative approach involving parents, attendance counsellors, and mental health professionals.
REFERENCES


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Appendix A: Parent Consent Form

Project Title: Increasing School Attendance and Decreasing Mental Health Symptomology for Children and Youth with School Refusal Behaviour Using a Functional Model and Cognitive Behaviour Therapy

Principal Investigators (students): Taylor Beaubien, Lindsay Drew, Holly Johnstone


Name of Institution: St. Lawrence College


Invitation
Your child is being invited to participate in a research study. Our names are Taylor Beaubien, Lindsay Drew, and Holly Johnstone and we are 4th year students at St. Lawrence College in the Honours Bachelor of Behavioural Psychology program. We are currently on placement at the hospital completing a research project called an Applied Thesis. We would like to ask for your help in completing this project. The information in this form will help you understand our project. Please read the information carefully and feel free to ask any questions before deciding if you want your child to take part.

Why is this research study being done?
This study will include interventions primarily based in applied behaviour analysis and/or cognitive behavioural therapy (CBT) depending on your child’s individual needs to help increase your child’s school attendance as well as hoping to decrease mental health symptoms associated with not attending school. It is believed that increasing your child’s school attendance while decreasing mental health symptoms will create a more enjoyable and successful learning environment and will likely benefit future school years.

What will your child need to do if he/she takes part?
If you choose to have your child take part in this study, the Behavioural Psychology student will complete an assessment, which may include a review your child’s health and school records and create a program that is based on cognitive-behavioural therapy techniques and individual needs of your child. This will take place during a 14-week timeline, from September
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to December 2017, under joint supervision of attendance counsellors and the hospital. The intervention program will include education relating to school refusal behaviour and strategies to increase attendance which may include relaxation exercises, discussing negative thoughts, behaviour techniques to overcome anxiety, rewards for attendance, and consequences for nonattendance.

Implementation of these techniques may involve the students meeting with your child, yourself, school staff, phoning or visiting your home in the morning, meeting your child at the bus stop or at his/her school, teaching coping strategies, and providing tangible rewards and praise for attending school. The number and length of individual sessions will vary depending on your child’s circumstances.

The student will collect data to see if the program was beneficial to your child, such as the number of days or hours attending school, skill acquisition, symptom reduction, and satisfaction of the program provided.

What are the potential benefits of taking part?

This study may benefit your child as it could increase his/her school attendance which will likely help in creating a positive and successful learning environment. It could also improve his/her mental health symptoms, particularly the anxiety shown towards school. By participating in this project, your child is also helping us complete a project for school.

What are the potential disadvantages or risks of taking part?

The risks of participating in this project are minimal; however, some stress and/or anxiety may be experienced within a session if discussing a situation that triggers your child or when having to participate in activities to increase school attendance.

What happens if something goes wrong?

If your child shows emotional distress during any of the sessions, attempts will be made to re-direct the session to a more positive focus. If an attempt to re-direct the session fail, and your child still shows signs of emotional distress, the session will end, and your child will have the opportunity to continue another day. If your child does have any strong reactions to the interview questions or activities during the session, he/she may ask to take a break, stop the session, talk to our supervisor, and/or remove oneself from the study.

Will the information you collect from my child in this project be kept private?

Any computer files with study data or information collected will be kept on the Behavioural Psychology student’s password protected computer for the duration of the study. Your child’s name will not be used in any component of the study (e.g. recordings, data). Your child will be assigned a code number that will be used in place of his/her name during the study and all information that could be used to identify your child will be removed. Research data will be kept in the psychology testing library file, in a locked cabinet, at the agency for 7 years, and consent forms will be kept until the child’s 28th birthday. After these timeframes, the data and consent forms will be shredded. Any clinical notes from individual sessions will be entered and stored in the patient care system, an electronic software that stores and protects client files. The results from the research are part of our theses and will be published and made available at the
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St. Lawrence College library. They may also be published in professional journals or presented at conferences, but any such presentations will be of general findings and will never breach individual confidentiality. We will make every attempt to keep any information that identifies your child strictly confidential unless required by law.

Does your child have to take part?

Taking part in this study is voluntary. It is up to you to decide whether you would like your child to take part in this research project. If you choose for your child not to participate or you choose to withdraw later, it will have no impact on his/her treatment at the agency. If you do decide for his/her to take part, you will be asked to sign this consent form. Even after consent is signed, you are free to remove your child from the study at any time and you are not required to provide a reason. If you choose to withdraw him/her from the study, you can ask that data not be used, and any information previously collected will be destroyed and the study will stop immediately.

Further Information

This project has been reviewed by the Research Ethics Board at St. Lawrence College and at the Queen’s Research Ethics Board. The project will be developed under the supervision of Marie-Line Jobin, my supervisor from St. Lawrence College and implemented under Beverly Blaney, Dr. Jennifer Davidson-Harden, and school counsellors. I appreciate your cooperation. If you have any additional questions or concerns feel free to ask us students; Holly Johnstone (hjohnstone05@student.sl.on.ca), Taylor Beaubien (tbeaubien25@student.sl.on.ca) or Lindsay Drew (ldrew20@student.sl.on.ca). You can also contact our College Supervisor Marie-Line Jobin (MJobin@sl.on.ca), or you may contact the St. Lawrence College Research Ethics Board at reb@sl.on.ca.

Consent

If you agree to participate in this research project, please complete the following page and return it to me as soon as possible. A copy of this signed document will be given to you and a copy will also be kept in a secure location.
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Parent Consent Form

By signing this form:
☐ I consent for my child to participate in this study and the results to be shared within the professional community.

By signing this form, I agree that:
☐ The project has been explained to me.
☐ All my questions have been answered.
☐ Possible risks and benefits of the study have been explained to me.
☐ I understand that I have the right to decline my child’s participation and the right to withdraw my child at any time.
☐ I am free now, and in the future, to ask any questions I have about the project.
☐ I understand that my information and identity will be kept confidential.
☐ I understand that I will receive a signed copy of this form.
☐ I consent for the data from this study to be presented at the St. Lawrence College Behavioural Psychology Poster Gala, at other conferences, or published in a scientific journal after removing identifying information.
☐ I understand that if the researcher or any of the staff members believes my child may cause harm to their self or others, they will report it to someone, withdraw my child from the program, and/or speak with me about it.

I hereby consent for my child to participate in this study.

Parent/Guardian Name (print): ______________________

Parent/Guardian Signed: _____________________

Date: ________________________

BPSYC Student Name (print): _______________________

BPSYC Student Signed: _______________________

Date: ________________________
Appendix B: Psychoeducation Consent Form

Project Title: Increasing School Attendance and Decreasing Mental Health Symptomology for Children and Youth with School Refusal Behaviour Using a Functional Model and Cognitive Behaviour Therapy

Principal Investigators (students): Taylor Beaubien, Lindsay Drew, Holly Johnstone


Name of Institution: St. Lawrence College


Invitation

You are being invited to take part in a research study. We are 4th year students in of the Honours of Behavioural Psychology program at St. Lawrence College and are completing a placement. As a part of this placement, we are completing a research project (called an applied thesis). We would like to ask you for your help to complete this project. The information in this form will help you understand our project. Please read the information carefully and ask all the questions you might have before you decide if you want to take part.

What is the research study being done?

Our project is focused on offering a psychoeducation workshop to parents that will assist them with understanding their child’s school attendance due to their mental health concerns. This can include topics such as information about mental health issues (i.e., anxiety or depression), school refusal behaviour, and behavioural techniques to help increase your child’s school attendance. The workshop will allow parents to learn and support each other in a positive environment.

What will you need to do if you take part?

If you choose to take part in this study, you will be asked to take part in 5 to 8 group workshops offered. However, individual sessions will be provided if you are unable to attend the group workshop (i.e. work schedule, transportation issues, etc.). The workshops will take place for one hour each week, for a total of 4 to 6 weeks. The group workshops will be run by us students (Holly, Taylor, and Lindsay) under the supervision of Marie Line-Jobin, Beverly Blaney, and Dr. Jennifer Davidson-Harden. At the last session of the workshop, we will ask you to fill out a feedback survey that will allow us to see if the workshop was helpful to you. This
survey will take about 10 minutes to fully complete. Your opinions and thoughts are important, and we are asking for your help to rate this program. This will help us understand if the program is successful and what could be changed to make the program more beneficial to other parents in the future.

**What are the potential benefits of taking part?**

The potential benefits of participating in this project may include learning more about yourself as a parent and strategies to help increase your child’s school attendance. It may also benefit you to meet other parents who may be experiencing some of the same issues/concerns as you. You may learn from the other parents in the workshop about skills that they use with their child that you may wish to try.

**What are the potential benefits of this research study to others?**

Feedback that you provide about the workshops may be used to make improvements for future psychoeducation workshops. This may benefit parents who participate in the workshops in the future.

**What are the potential risks or disadvantages of taking part?**

The risks of participating in this project are minimal. If you experience any strong reactions or feelings during the workshop, you may ask to take a break, talk one of the students or supervisors, and/or remove yourself from the study.

**What happens if something goes wrong?**

Every individual within the psychoeducation group is different and may have alternative parenting styles or beliefs. If you experience any strong reactions towards any topics or questions discussed within the group, my supervisor, or us students are available to talk to with you.

**Will the information collected in this study be kept private?**

We will make every attempt to keep any information that identifies you strictly confidential unless required by law. Your name or any identification will not be used in the study; you will be assigned a code number that will be used in place of your name during the study. The feedback survey will only be reviewed by the researcher and my supervisor. The consent forms and completed survey will be kept in a locked filing cabinet. Any computer files with data from the study will be kept on a password protected computer. All the data within the study will be kept in a secure location within the agency for 7 years, which will then be shredded. The results from the project are a part of our research for our theses and will be published and available at the St. Lawrence College library. Additionally, there may be presentations or conferences where the project is discussed of the findings but will maintain individual confidentiality.

**Do you have to take part?**

Taking part in the project is voluntary. It is your decision of whether you want to take part in the research project. If you decide to take part in the project, you will be asked to sign the consent form provided. If you do decide to participate, you have the option to stop participating in the project at any given time without giving a reason and without any negative consequences. If you choose to remove yourself from the study, please inform us students or our supervisor.
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Upon removing yourself from the study, you can ask for your data to not be used within the project which then be safely destroyed.

Further information

This project has been reviewed by the Research Ethics Board at St. Lawrence College and at the Queen’s Research Ethics Board. The project will be developed under the supervision of Marie-line Jobin, our supervisor from St. Lawrence College and Beverly Blaney and Dr. Jennifer Davidson-Harden, our agency supervisors. I appreciate your cooperation. If you have any additional questions or concerns feel free to ask us students; Holly Johnstone (hjohnstone05@student.sl.on.ca), Taylor Beubien (tbeubien25@student.sl.on.ca) or Lindsay Drew (ldrew20@student.sl.on.ca). You can also contact our College Supervisor Marie-Line Jobin (MJobin@sl.on.ca), or you may contact the St. Lawrence College Research Ethics Board at reb@sl.on.ca.

Consent

If you agree to take part in this research project, please complete the following page and return it to me as soon as possible. A copy of this signed document will be given to you for your own records. An additional copy of your consent will be retained at the agency and (if applicable) in a secure location at St. Lawrence College.
Psychoeducation Consent Form

By signing this form:

☐ I consent to participate in this study and the results to be shared within the professional community.

By signing this form, I agree that:

☐ The project has been explained to me.
☐ All my questions have been answered.
☐ Possible risks and benefits of the study have been explained to me.
☐ I understand that I have the right not to take part and the right to stop at any time.
☐ I am free now, and in the future, to ask any questions I have about the project.
☐ I understand that my information and identity will be kept confidential.
☐ I understand that I will receive a signed copy of this form.
☐ I consent for the data from this study to be presented at the St. Lawrence College Behavioural Psychology Poster Gala, at other conferences, or published in a scientific journal after removal of identifying information.
☐ I understand that if the researcher or any of the staff members believes I may cause harm to myself or others, they will report it to someone.

By signing this I consent to participate in this study.

Parent/Guardian Name (print): _______________________

Parent/Guardian Signed: _______________________

Date: _______________________

BPSYC Student Name (print): _______________________

BPSYC Student Signed: _______________________

Date: _______________________
Appendix C: Self-Compassion Scale

HOW I TYPICALLY ACT TOWARDS MYSELF IN DIFFICULT TIMES

Please read each statement carefully before answering. To the left of each time, indicate how often you behave in the stated manner, using the following scale:

<table>
<thead>
<tr>
<th></th>
<th>Almost Never</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Almost always</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td></td>
</tr>
</tbody>
</table>

1. I’m disapproving and judgmental about my own flaws and inadequacies.
2. When I’m feeling down I tend to obsess and fixate on everything that’s wrong.
3. When things are going badly for me, I see the difficulties as part of life that everyone goes through.
4. When I think about my inadequacies, it tends to make me feel more separate and cut off from the rest of the world.
5. I try to be loving towards myself when I’m feeling emotional pain.
6. When I fail at something important to me I become consumed by feelings of inadequacy.
7. When I’m down and out, I remind myself that there are lots of other people in the world feeling like I am.
8. When times are really difficult, I tend to be tough on myself.
9. When something upsets me I try to keep my emotions in balance.
10. When I feel inadequate in some way, I try to remind myself that feelings of inadequacy are shared by most people.
11. I’m intolerant and impatient towards those aspects of my personality I don’t like.
12. When I’m going through a very hard time, I give myself caring and tenderness I need.
13. When I’m feeling down, I tend to feel like most other people are probably happier than I am.
14. When something painful happens, I try to take a balanced view of the situation.
15. I try to see my failings as part of the human condition.
16. When I see aspects of myself that I don’t like, I get down on myself.
17. When I fail at something important to me I try to keep things in perspective.
18. When I’m really struggling, I tend to feel like other people must be having an easier time of it.
19. I’m kind to myself when I’m experiencing suffering.
20. When something upsets me I get carried away with my feelings.
21. I can be cold-hearted towards myself when I’m experiencing suffering.
22. When I’m feeling down I try to approach my feelings with curiosity and openness.
23. I’m tolerant of my own flaws and inadequacies.
24. When something painful happens I tend to blow the incident out of proportion.
25. When I fail at something that’s important to me, I tend to feel alone in my failure.

26. I try to be understanding and patient towards those aspects of my personality I don’t like.
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Appendix D: School Refusal Assessment Scale- Revised- Child

Please circle the answer that best fits the following questions

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
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<tbody>
<tr>
<td>0</td>
<td>1</td>
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<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
</tr>
</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
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<td>6</td>
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</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
<th>Always</th>
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</thead>
<tbody>
<tr>
<td>0</td>
<td>1</td>
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<td>3</td>
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<td>5</td>
<td>6</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Half the Time</th>
<th>Usually</th>
<th>Almost Always</th>
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</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Never</th>
<th>Seldom</th>
<th>Sometimes</th>
<th>Half the Time</th>
<th>Usually</th>
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</tr>
</tbody>
</table>

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

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

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

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</table>
INCREASING SCHOOL ATTENDANCE

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

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

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

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

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

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

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

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

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

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Total Score

Mean Score

Relative Ranking
INCREASING SCHOOL ATTENDANCE

Appendix E: School Refusal Assessment Scale - Parent

Please circle the answer that best fits the following questions:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

   | Never | Seldom | Sometimes | Half the Time | Usually | Almost Always | Always |
   | 0     | 1      | 2         | 3             | 4       | 5             | 6      |
### Increasing School Attendance

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

<table>
<thead>
<tr>
<th>Never</th>
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#### 10. How often does your child stay away from school because he/she does not have any friends there?

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#### 11. How often would your child rather be away from his/her family than go to school?

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

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

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

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

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

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

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INCREASING SCHOOL ATTENDANCE

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

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

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

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

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

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

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

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Total _______ _______ _______ _______

Score

Mean _______ _______ _______ _______

Score

Relative _______ _______ _______ _______

Ranking
### Table 1
**Session Content for Participant 1**

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<tr>
<th>Session</th>
<th>Content Covered</th>
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<tbody>
<tr>
<td>1</td>
<td>• Obtained verbal assent from participant and discussed next steps.</td>
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<td>• Participant agreed to working toward taking the bus to school to arrive earlier.</td>
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<td>2</td>
<td>• Participant completed BYI-II.</td>
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<td></td>
<td>• Introduced and discussed CBT model, factors that contribute to anxiety,</td>
</tr>
<tr>
<td></td>
<td>and fight/flight/freeze and relaxation responses.</td>
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<tr>
<td></td>
<td>• Provided online resources to practice breathing exercises.</td>
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<td>• Participant completed SCS and SRAS-R child version</td>
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<td></td>
<td>• Collaboratively created a fear hierarchy with participant, identifying</td>
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<td>steps to taking the bus to school when it is crowded, with anticipated</td>
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<td>anxiety ratings for each step.</td>
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<tr>
<td>4</td>
<td>• Introduced and discussed thought records and progressive muscle relaxation.</td>
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<tr>
<td>5</td>
<td>• Introduced and discussed cognitive distortions and thought challenge,</td>
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<td>‘Examine the Evidence’.</td>
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<td>6</td>
<td>• Completed check in and discussed plan for support moving forward.</td>
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</table>
Table 2
*Session Content for Participant 2*

<table>
<thead>
<tr>
<th>Session</th>
<th>Content Covered</th>
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</table>
| 1       | • Introduced and explained CBT model and factors that contribute to anxiety.  
• Completed exercise to identify physical sensations experienced when anxious.  
• Introduced and explained fight/flight/freeze and relaxation responses.  
• Introduced calm breathing and provided online resources to practice breathing exercises. |
Appendix H: Session Content for Parent Group

Table 3
Session Content for Parent Participant

<table>
<thead>
<tr>
<th>Session</th>
<th>Content Covered</th>
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</table>
| 1       | • Pre-measure (questionnaire with ratings for confidence in supporting children with mental health and school attendance).  
          • Discussed school-refusal, what this may look like, and reasons that children may avoid school.  
          • Introduced and explained CBT model.  
          • Introduced stress behaviour vs. misbehavior to help parents identify signs that their child is in distress.  
          • Discussed fight/flight/freeze and relaxation responses and provided online resources for parents to practice relaxation exercises. |
| 2       | • Introduced difference between anxiety and fear, and how to tell when anxiety is problematic.  
          • Discussed labelling to reduce intense emotions and provided parents with examples.  
          • Provided example questions for parents to obtain more information about their child’s negative thoughts.  
          • Introduced cognitive distortions and thought challenges. |
| 3       | • Discussed stress, stressors, self-regulation, and self-care.  
          • Provided 4-step model for reducing stress and had parents brainstorm ideas for individual and family self-care.  
          • Introduced and discussed behavioural strategies to help parents support their children with mental health symptoms and school attendance, including reinforcement, prompts, and chaining. |
| 4       | • Prompted parents to discuss behavioural strategies previously tried, whether they were effective, and parent perception of why.  
          • Discussed learning challenges and IEPs, with parents sharing their experience with school supports. |
INCREASING SCHOOL ATTENDANCE

- Provided strategies to advocate for children, and examples of assertive statements to teach children self-advocacy.

5

- Reviewed key concepts covered during sessions using online Jeopardy game.

- Parents provided feedback about the group and post-ratings of their confidence in supporting their child with mental health symptoms and school attendance.
Appendix I: SRAS-R Results for Participant 1

Table 1
*SRAS-R Scores and Relative Rankings for Potential Functions*

<table>
<thead>
<tr>
<th>Function</th>
<th>Total Score</th>
<th>Mean Score</th>
<th>Relative Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance</td>
<td>4</td>
<td>.67</td>
<td>2</td>
</tr>
<tr>
<td>Escape</td>
<td>5</td>
<td>.83</td>
<td>2</td>
</tr>
<tr>
<td>Attention</td>
<td>20</td>
<td>3.33</td>
<td>1</td>
</tr>
<tr>
<td>Tangible</td>
<td>3</td>
<td>.50</td>
<td>2</td>
</tr>
</tbody>
</table>
## Appendix J: BYI-II and SCS Pre-Intervention Scores for Participant 1

Table 2  
*BYI-II and SCS Subscale Pre-Intervention Scores for Participant 1*

<table>
<thead>
<tr>
<th>Measure and Subscale</th>
<th>Pre-Intervention Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>BYI-II</strong></td>
<td></td>
</tr>
<tr>
<td>BDSCI-Y</td>
<td>41</td>
</tr>
<tr>
<td>BAI</td>
<td>56</td>
</tr>
<tr>
<td>BDI</td>
<td>39</td>
</tr>
<tr>
<td>BANI-Y</td>
<td>41</td>
</tr>
<tr>
<td>BDBI-Y</td>
<td>44</td>
</tr>
<tr>
<td><strong>SCS</strong></td>
<td></td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>2.20</td>
</tr>
<tr>
<td>Self-Judgement*</td>
<td>1.60</td>
</tr>
<tr>
<td>Common Humanity</td>
<td>2.00</td>
</tr>
<tr>
<td>Isolation*</td>
<td>1.50</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>2.50</td>
</tr>
<tr>
<td>Over-Identification*</td>
<td>1.25</td>
</tr>
</tbody>
</table>

Note: * indicates items that have been reverse scored.
INCREASING SCHOOL ATTENDANCE

Appendix K: Weekly Attendance Data for Participant 1

Table 3
Weekly Attendance Data for Participant 1

<table>
<thead>
<tr>
<th>Week</th>
<th>Number of Classes Attended</th>
<th>Total Number of Classes</th>
<th>Percentage of Classes Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Baseline</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-Sept-17</td>
<td>9</td>
<td>20</td>
<td>45.00%</td>
</tr>
<tr>
<td>11-Sept-17</td>
<td>12</td>
<td>25</td>
<td>48.00%</td>
</tr>
<tr>
<td>18-Sept-17</td>
<td>7</td>
<td>25</td>
<td>28.00%</td>
</tr>
<tr>
<td>25-Sept-17</td>
<td>7</td>
<td>20</td>
<td>35.00%</td>
</tr>
<tr>
<td>2-Oct-17</td>
<td>10</td>
<td>25</td>
<td>40.00%</td>
</tr>
<tr>
<td>9-Oct-17</td>
<td>6</td>
<td>20</td>
<td>30.00%</td>
</tr>
<tr>
<td>16-Oct-17</td>
<td>10</td>
<td>25</td>
<td>40.00%</td>
</tr>
<tr>
<td>23-Oct-17</td>
<td>16</td>
<td>20</td>
<td>80.00%</td>
</tr>
<tr>
<td>30-Oct-17</td>
<td>12</td>
<td>25</td>
<td>48.00%</td>
</tr>
<tr>
<td>Intervention</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6-Nov-17</td>
<td>19</td>
<td>25</td>
<td>76.00%</td>
</tr>
<tr>
<td>13-Nov-17</td>
<td>11</td>
<td>25</td>
<td>44.00%</td>
</tr>
<tr>
<td>20-Nov-17</td>
<td>11</td>
<td>20</td>
<td>55.00%</td>
</tr>
<tr>
<td>27-Nov-17</td>
<td>3</td>
<td>25</td>
<td>12.00%</td>
</tr>
<tr>
<td>4-Dec-17</td>
<td>20</td>
<td>25</td>
<td>80.00%</td>
</tr>
<tr>
<td>11-Dec-17</td>
<td>4</td>
<td>25</td>
<td>16.00%</td>
</tr>
</tbody>
</table>

Average percentage of classes attended during baseline: 43.00%
- Classes attended: 9+12+7+7+10+6+10+16+12 = 89
- Divide classes attended by total classes: 89/205 = 0.43
- Multiply by 100: 0.43x100 = 43.00

Average percentage of classes attended during intervention: 47.00%
- Classes attended: 19+11+11+3+20+4 = 68
- Divide classes attended by total classes: 68/145 = 0.47
- Multiply by 100: 0.47x100 = 47.00

Increase of average attendance from baseline to intervention: 4.00%
- Difference: 47.00-43.00 = 4.00
INCREASING SCHOOL ATTENDANCE

Graphical representation of baseline and intervention attendance data for participant 1 with trend lines.

Stability during baseline:
- Determine median level for baseline data points: 28, 30, 35, 40, 40, 45, 48, 48, 80 = 40
- Find values 12.5 above and below median level: 40+12.5 = 55.5, 40-12.5 = 27.5
- Determine percentage of data points between 27.5 and 55.5: ((8/9) x100) = 88.00%

Stability during intervention:
- Determine median level for baseline data points: 12, 16, 44, 55, 76, 80 = 55+76/2 = 65.5
- Find values 12.5 above and below median level: 65.5+12.5 = 78, 65.5-12.5 = 53
- Determine percentage of data points between 53 and 78: ((2/6) x100) = 33.00%

PEM:
- Determine median for graphed data points: 28, 30, 35, 40, 40, 45, 48, 48, 80 = 40
- Determine percentage of data points above median level in intervention phase: ((4/6) x100 = 66.66%
Appendix L: SRAS-R Results for Participant 2

Table 4
SRAS-R Scores and Relative Rankings for Potential Functions

<table>
<thead>
<tr>
<th>Function</th>
<th>Mean Score P1</th>
<th>Mean Score P2</th>
<th>Mean Score</th>
<th>Relative Ranking</th>
</tr>
</thead>
<tbody>
<tr>
<td>Avoidance</td>
<td>3.5</td>
<td>3.33</td>
<td>3.41</td>
<td>1</td>
</tr>
<tr>
<td>Escape</td>
<td>2.33</td>
<td>1.33</td>
<td>1.83</td>
<td>2</td>
</tr>
<tr>
<td>Attention</td>
<td>1.92</td>
<td>1.33</td>
<td>1.62</td>
<td>2</td>
</tr>
<tr>
<td>Tangible</td>
<td>1.67</td>
<td>1.5</td>
<td>1.58</td>
<td>2</td>
</tr>
</tbody>
</table>
### Appendix M: Weekly Attendance Data for Participant 2

#### Table 5

**Weekly Attendance Data for Participant 2**

<table>
<thead>
<tr>
<th>Week</th>
<th>Number of Days Attended</th>
<th>Total Number of Days</th>
<th>Percentage of Days Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Baseline</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4-Sept-17</td>
<td>3</td>
<td>4</td>
<td>75.00%</td>
</tr>
<tr>
<td>11-Sept-17</td>
<td>3</td>
<td>5</td>
<td>60.00%</td>
</tr>
<tr>
<td>18-Sept-17</td>
<td>3</td>
<td>5</td>
<td>60.00%</td>
</tr>
<tr>
<td>25-Sept-17</td>
<td>2</td>
<td>4</td>
<td>50.00%</td>
</tr>
<tr>
<td>2-Oct-17</td>
<td>2</td>
<td>5</td>
<td>40.00%</td>
</tr>
<tr>
<td>9-Oct-17</td>
<td>2</td>
<td>4</td>
<td>50.00%</td>
</tr>
<tr>
<td>16-Oct-17</td>
<td>1</td>
<td>5</td>
<td>20.00%</td>
</tr>
<tr>
<td>23-Oct-17</td>
<td>2</td>
<td>4</td>
<td>50.00%</td>
</tr>
<tr>
<td>30-Oct-17</td>
<td>2</td>
<td>5</td>
<td>40.00%</td>
</tr>
<tr>
<td>6-Nov-17</td>
<td>2</td>
<td>5</td>
<td>40.00%</td>
</tr>
<tr>
<td><strong>Intervention</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>13-Nov-17</td>
<td>3</td>
<td>5</td>
<td>60.00%</td>
</tr>
<tr>
<td>20-Nov-17</td>
<td>0</td>
<td>5</td>
<td>00.00%</td>
</tr>
<tr>
<td>27-Nov-17</td>
<td>1</td>
<td>5</td>
<td>20.00%</td>
</tr>
<tr>
<td>4-Dec-17</td>
<td>0</td>
<td>5</td>
<td>00.00%</td>
</tr>
<tr>
<td>11-Dec-17</td>
<td>2</td>
<td>5</td>
<td>40.00%</td>
</tr>
</tbody>
</table>

Average percentage of days attended during baseline: 47.00%
- Days attended: = 3+3+3+2+2+2+1+2+2+2 = 22
- Total days: 4+5+5+4+5+4+5+4+5+5 = 46
- Divide days attended by total days: 22/46 = 0.47
- Multiply by 100: 0.47x100 = 47.00

Average percentage of days attended during intervention: 24.00%
- Days attended: 3+0+1+0+2 = 6
- Total days: 5+5+5+5+5 = 25
- Divide days attended by total days: 6/25 = 0.24
- Multiply by 100: 0.24x100 = 24.00

Increase of average attendance from baseline to intervention: -23.00%
- Difference: 47.00-24.00 = -23.00
Graphical representation of baseline and intervention attendance data for participant 2 with trendlines.

Stability during baseline:
- Determine median level for baseline data points: 20, 40, 40, 40, 50, 50, 50, 60, 60, 75 = 50
- Find values 12.5 above and below median level: \(50 + 12.5 = 62.5\), \(50 - 12.5 = 37.5\)
- Determine percentage of data points between 37.5 and 62.5: \(((8/10) \times 100) = 80.00\%\)

Stability during intervention:
- Determine median level for baseline data points: 0, 0, 20, 40, 60 = 20
- Find values 12.5 above and below median level: \(20 + 12.5 = 32.5\), \(20 - 12.5 = 7.5\)
- Determine percentage of data points between 7.5 and 32.5: \(((1/5) \times 100) = 20.00\%\)

PEM:
- Determine median for graphed data points: 20, 40, 40, 40, 50, 50, 50, 60, 60, 75 = 50
- Determine percentage of data points above median level in intervention phase: \(((1/5) \times 100 = 20.00\%)\)
Appendix N: Parent Feedback Questionnaire Pre-Test

1. Have you ever attended a parent support group?  Y   N

2. What would you like to learn during this group?

______________________________________________________________________________

3. If there is one thing you would like to be able to do after completing this group that might be difficult for you now, what would it be?

______________________________________________________________________________

4. On a scale of 1 (not at all) to 5 (very), how confident are you in getting your child to school on a regular basis?

   1    2    3    4    5

5. On a scale of 1 (not at all) to 5 (very), how confident are you in helping your child calm down when they are worried or anxious?

   1    2    3    4    5
Appendix O: Parent Feedback Questionnaire Post-Test

1. What did you learn during this group?
______________________________________________________________________________
______________________________________________________________________________

2. What is one thing that you enjoyed about the group?
______________________________________________________________________________
______________________________________________________________________________

3. What is one thing that could improve this group?
______________________________________________________________________________
______________________________________________________________________________

4. On a scale of 1 (not at all) to 5 (very), how confident are you in getting your child to school on a regular basis?

1 2 3 4 5

5. On a scale of 1 (not at all) to 5 (very), how confident are you in helping your child calm down when they are worried or anxious?

1 2 3 4 5

6. Comments:
______________________________________________________________________________
______________________________________________________________________________
Appendix P: Pre- and Post-Test Scores on Parent Feedback Questionnaire

Table 6
Pre- and Post-Test Scores for Parent Feedback Questionnaire

<table>
<thead>
<tr>
<th>Question</th>
<th>Pre-Score</th>
<th>Post-Score</th>
<th>Score Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Question 4</td>
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<td></td>
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</tr>
<tr>
<td>Parent 1</td>
<td>3</td>
<td>3</td>
<td>0.00</td>
</tr>
<tr>
<td>Parent 2</td>
<td>2</td>
<td>1</td>
<td>-1.00</td>
</tr>
<tr>
<td>Parent 3</td>
<td>-</td>
<td>3</td>
<td>-</td>
</tr>
<tr>
<td>Question 5</td>
<td></td>
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<tr>
<td>Parent 1</td>
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<td>4</td>
<td>0.00</td>
</tr>
<tr>
<td>Parent 2</td>
<td>3</td>
<td>3</td>
<td>0.00</td>
</tr>
<tr>
<td>Parent 3</td>
<td>-</td>
<td>4</td>
<td>-</td>
</tr>
</tbody>
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