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

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Abstract

Over the past decade, there has been a significant increase in emergency department visits and hospitalizations for children and youth seeking treatment for mental health concerns in Ontario. In addition, a substantial amount of children and youth remain on a waitlist for over a year before receiving services. Unaddressed mental health concerns can also affect children and youth by interfering with regular school attendance. The research literature conveys the effectiveness of behavioural approaches and Cognitive Behavioural Therapy (CBT) for addressing mental health concerns and school refusal behaviour. In addition, utilizing a collaborative approach between school staff, mental health professionals, the clients, and their parents can enhance the intervention effectiveness to increase school attendance. The current study hypothesized that the use of a functional model and CBT, with a collaborative approach between multiple professionals, should increase school attendance and decrease the severity of mental health symptoms among the selected youth. Participants included a 15-year-old female and a 10-year-old male. Participant 1 did not have a formal mental health, but displayed school refusal behaviour and symptoms of anxiety and depression. Participant 2 was diagnosed with attention deficit disorder, anxiety, a mood disorder, and displayed school refusal behaviour in the previous school year. The intervention consisted of psychoeducation in regard to anxiety using cognitive and behavioural principles, and practicing coping skills using a CBT manual for anxiety and a modified CBT approach for anger. Each participant completed the School Refusal Assessment Scale – Revised – Child (SRAS-R-C) and Beck Youth Inventory – Second Edition (BYI-II). Participant 1 also completed the Self Compassion Scale (SCS). Additionally, attendance records were obtained from the school board following the intervention for each participant. The results proved to be clinically effective as participants experienced less severe mental health symptomology and a consistent or increase in school attendance. In conclusion, the strengths of this study included an individualized treatment approach, a collaborative approach between multiple professionals, and teaching coping skills in multiple environments. Future research should focus on duplicating the research study with a larger sample size and with increased parent involvement throughout the intervention.
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Chapter I – Introduction

According to Children’s Mental Health Ontario ([CMHO], 2017), 1 in 4 children will encounter a mental health concern prior to the age of 18. Over the past decade, there has been an increase of 54% in emergency department visits and an increase of 60% in hospitalizations for children and youth in Ontario seeking treatment for mental health concerns (CMHO, 2017). Despite this statistic, waitlists for treatment continue to grow while more than 6,500 children and youth remain on a waitlist for over a year before receiving services (CMHO, 2017). Unaddressed mental health concerns or prolonged waitlists can affect children and youth in the long term by interfering with regular school attendance, which may lead to social and/or occupational problems in adulthood (Kearney, 2003).

Kearney and Silverman (1996) proposed a definition of school-refusal behaviour comprised of the variety of forms that children and youth may display:

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 behaviour problems such as morning temper tantrums, and/or (d) display unusual distress during school days that precipitates pleas for future nonattendance. (p. 345)

School refusal can either be categorized as acute, which refers to refusal that is sustained for at least two weeks but less than a year, or chronic, which refers to refusal that persists for more than a year (Kearney & Silverman, 1996). According to CMHO (2017), 73% of teachers concluded that anxiety disorders show to be a pressing concern within the school environment, indicating that it is a significant issue. For students with mental health concerns or learning disabilities, the school may become an aversive environment and create a barrier to regular attendance. Irregular attendance can interfere with a student’s academic success and increase the likelihood of dropout rates. As children and youth spend a greater part of their time in the school environment, irregular attendance can lead to limited opportunities for the development of quality relationships with their peers and appropriate social skills, as well as contribute to family conflict and/or dysfunction (Heyne, Sauter, van Widenfelt, Vermeiren, & Westenberg, 2011; King & Bernstein, 2001).

Kearney (2003) states that to develop an effective intervention to increase school attendance, it is critical to utilize a collaborative approach between school staff, mental health professionals, and parents. Gittell (2013) indicates that learning from, about, and with other professionals increases the development of more effective interventions when working together as a team or collaborative group. In addition, increased collaboration with parents is also very important (Kearney, 2008). The more frequent contact with parents, the greater the chances are of resolving school refusal behaviour as increased levels of parent involvement are predictive of more effective intervention outcomes for the child (Kearney 2008 & Pereira, 2016). The aim of this thesis is to increase the participants’ school attendance and decrease the severity of their mental health symptoms. In addition, this thesis aims to increase the youth’s and their parent’s knowledge regarding school refusal behaviour, mental health concerns, and behavioural and cognitive strategies that can be used in order to increase school attendance.

This thesis is being completed as part of the School Attendance Project and involves a joint collaboration between Ontario school boards’ attendance counsellors, Children and Youth Mental Health Outpatient Services mental health professionals, the faculty and students of the Honours Bachelor of Behavioural Psychology Degree Program at St. Lawrence College, and the
St. Lawrence College Centre for Behavioural Studies. This project began in the spring of 2017 and seeks to increase attendance concerns such as sporadically attending, refusing to attend at all, or having difficulties staying for a full day in school. The School Attendance Project was designed to provide a comprehensive, multi-agency intervention program to best address the needs of students engaging in school refusal behaviour. This project uses evidence-based cognitive and behavioural methods with the aim to increase school attendance of elementary and secondary school students who have mental health concerns.

Rationale

An area of concern for delivery of mental health services suggested by CMHO (2017) is the lack of coordination between multiple professionals including child psychiatrists, schools, children’s mental health centers, etc. The required action would be to develop a consensus around working together as one large system to engage youth, their families, and service providers across the child and youth mental health system. In general, behavioural approaches towards school refusal behaviour appear to be effective, while several studies convey the effectiveness of Cognitive Behavioural Therapy (CBT) for school refusal behaviour. Therefore, it is hypothesized that the use of a functional model and CBT, with a collaborative approach between multiple professionals, should increase school attendance and decrease the severity of mental health symptoms among the selected youth.

Thesis Overview

This thesis is composed of several chapters. The literature review analyzes peer-reviewed and empirically validated articles on mental health concerns, multiple treatments for these concerns, techniques for increasing school attendance, the importance of a collaborative approach between professionals, parent involvement, and the benefits of a student practicum. The method chapter describes the procedures of the study, which includes information regarding the participants, research design, measures, and materials. The results chapter presents the study’s results and provides analyses of outcomes achieved. Lastly, the conclusion and discussion chapters provide an overall summary of the research study, covering the strengths, limitations, challenges, and contributions to the Behavioural Psychology field including opportunities for future research.
Chapter II – Literature Review

Anxiety

Anxiety is an adaptive and common response that assists individuals prepare for potential situations that may be harmful (Kendall et al., 2016). According to Swan and Kendall (2016), the most common psychological disorder that affects children and adolescents are anxiety disorders. Kendall et al., (2016) state that anxiety varies depending on the content of the distress, the development of the distress, and surrounding contextual factors. When delivering interventions to address anxiety, it is important to consider the age of the individual, the intensity and stability of the anxiety, and the interference in the child’s and family’s functioning caused by the anxiety (Swan & Kendall, 2016). Kendall et al. (2016) conclude that understanding the context of anxiety can help distinguish between the true presentation of the disorder and symptoms associated with other mental health concerns.

Treatment Overview

Kendall et al. (2016) emphasize that there are many treatments appropriate for anxiety at any level of severity, and no one type of treatment is the most accessible, efficient, or effective intervention for all anxious youth. Not all children and/or adolescents require the same intensity of care (Kendall et al., 2016). According to Kearney (2007), a serious issue studied by education and mental health professionals is school refusal, which includes refusing to attend and/or difficulty remaining in class for the entire school day. A complex and important responsibility of education and mental health professionals includes successful management of problems regarding school attendance (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011). School refusal behaviour that is anxiety-based is a type of attendance concern usually described as the child and/or adolescent who have difficulty being in the school environment and also experience significant levels of anxiety (Heyne, Sauter, Van Widenfelt, Vermeiren, & Westenberg, 2011). Kearney (2008) states that effective clinical interventions are designed to reduce mental health symptoms and assist in reintegrating a child and/or adolescent back into a classroom setting. There is an abundant amount of evidence regarding the effectiveness of CBT for treating children and adolescents who have anxiety disorders (Pereira et al., 2016). Similarly, according to Heyne, Sauter, Van Widenfelt, Vermeiren, and Westenberg (2011), CBT is the most commonly evaluated approach with significant outcomes for promoting school attendance, while also reducing symptoms of mental health.

Cognitive Behavioural Therapy (CBT). Kendall et al. (2016) explains that CBT often incorporates psychoeducation of anxiety related to feared situations, relaxation techniques to help manage somatic symptoms, cognitive restructuring to recognize anxiety-provoking thinking, learning coping skills, and gradual exposure to feared stimuli. The goals of these intervention methods are to assist children and/or adolescents manage their anxiety and increase daily attendance (Kearney, 2008). In addition, interventions conducted by Kearney (2008) intended to assist parents learn to appropriately reward school attendance and punish nonattendance. Whether CBT is delivered in individual or group format, treatment effects have shown to be comparable in both children and adolescents, in which reductions in anxiety are maintained up to several years following treatment (Kendall et al., 2016).

According to Chiu et al. (2013), clinical trials in a school environment are required to determine if CBT would be effective when applied to a real world setting. Children are able to receive mental health services in a variety of settings, in which school settings could be a logical
first choice (Chiu et al., 2013). A school setting is an ideal place to deliver CBT treatments due to the direct access to children affected and the impact anxiety has on a student’s academic functioning (Chiu et al., 2013). The study conducted by Chiu et al. (2013) evaluated the success of a modular CBT program for children with anxiety delivered in two elementary schools. Forty children between the age of 5 and 12 years old who were referred from teachers and school staff were randomized to either immediate modular CBT or a 3-month waitlist. Chiu et al. (2013) added that the use of a modular design allows clinicians to individualize treatments to each child’s specific needs. The Building Confidence intervention, a CBT program, was developed into a modular format (Chiu et al., 2013). This intervention included acquiring coping skills, with a primary focus relating to exposure therapy, developing coping thoughts, thought awareness, and positive self-talk (Chiu et al., 2013). Caregivers were given the opportunity to participate, were provided with a psychoeducation module, and were involved with the development of a fear hierarchy (Chiu et al., 2013). According to Chiu et al. (2013), 95% of the children receiving modular CBT showed a positive treatment response and greater anxiety symptom reduction reported by both the parent and the child at the end of treatment, in contrast to the children on the waitlist. Although the study was unable to demonstrate statistically significant differences between the waitlist condition and modular CBT, delivering CBT programs in a school environment could increase the amount of children provided with treatment for anxiety (Chiu et al., 2013). Chiu et al. (2013) also suggest that psychoeducation may assist caregivers and school staff identify features of anxiety, and learn more about available mental health services in order for them to recognize the value in early intervention.

Lundkvist-Houndoumadi, Thastum, and Hougaard (2016) conducted a study to examine the effectiveness of CBT based on an individualized case formulation with youths 9-17 years old with anxiety. Similarly to Chiu et al. (2013), their study was conducted following unsuccessful treatment based on a manualized CBT program delivered in a group format. The individualized case formulation model allowed for therapy to be flexible in order to tailor components of the treatment to each child’s specific needs (Lundkvist-Houndoumadi et al., 2016). The goal of this model was to increase the families’ understanding of the strategies learned, in order for their child to work independently, and to enhance the amount of time their child spends on exposure activities (Lundkvist-Houndoumadi et al., 2016). Lundkvist-Houndoumadi et al.’s (2016) model encourages a collaborative approach with the family, as therapists are able to flexibly address the difficulties that families may have during therapy. The manualized Cool Kids intervention was comprised of 10 weekly group sessions, with treatment components of psychoeducation, gradual exposure, and cognitive restructuring (Lundkvist-Houndoumadi et al., 2016). The individualized model used was based on principles of CBT and behavioral experiments, including video-feedback and social-skills training, as well as encouraging parents to use contingency management to promote the independence of their child (Lundkvist-Houndoumadi et al., 2016). Results indicated that the children’s levels of anxiety significantly decreased following individualized treatment, with this outcome remaining stable at the 1-year follow-up (Lundkvist-Houndoumadi et al., 2016). However, when anxiety was examined per individual, the evaluation provided by the clinician was not always consistent with the level of anxiety in each participant’s self-report (Lundkvist-Houndoumadi et al., 2016). Also, families reported that they were highly satisfied with their child’s treatment, especially because the parents’ active involvement was associated with greater long-term outcomes (Lundkvist-Houndoumadi et al., 2016). Lundkvist-Houndoumadi et al. (2016) concluded that overall, the individualized case formulation showed to be effective for youth with anxiety, who had not benefited from the manualized CBT program.
Heyne et al. (2011) evaluated the efficacy of developmentally sensitive CBT for adolescents with anxiety-based school refusal behaviour. Participants included 20 adolescents with school refusal behaviour meeting the DSM-IV criteria for anxiety disorder, as well as their parents, and school staff (Heyne et al., 2011). A developmentally sensitive manualized and modular CBT intervention was provided to the adolescents, the parents, and school staff (Heyne et al., 2011). The @School program was implemented individually and consisted of modules that incorporated psychoeducation relating to school refusal, managing stress, setting goals, and attending school. The modules were provided to the parents as well (Heyne et al., 2011). Results by Heyne et al. (2011) indicated improvements surrounding school attendance and a significant reduction in school-related fear and anxiety through self-report measures, which was also corroborated by the parents. Parents reported an increase in self-efficacy around managing their child’s school refusal behavior (Heyne et al., 2011). In addition, the involvement of parents may have assisted their children with support and empowerment as the interventions were tailored to their children (Heyne et al., 2011). The use of modularization allowed for individualized treatment through the selection, time, and pace of therapeutic strategies (Heyne et al., 2011).

In contrast, Tolin et al. (2009) suggest that intensive CBT may be more effective rather than implementing weekly treatment. The benefits of increasing the frequency of sessions include being able to address the effects of not attending school quickly and correcting homework concerns immediately (Tolin et al., 2009). The goal of their study was to assess the use of intensive (daily) CBT for 4 adolescents with school refusal behaviour, testing a CBT model that was tailored to each student’s function of their behaviour (Tolin et al., 2009). The adolescents were referred by their public school staff and were given a binder to record daily school attendance with the help of their parents (Tolin et al., 2009). Tolin et al.’s (2009) study was derived from specific CBT techniques established in school refusal programs for 15 sessions, delivered 5 days a week for 3 weeks, which took place in the office, at home, or at school. These techniques included direct exposure to feared situations, contingency management for parents, behavioural rehearsal, motivational interviewing, cognitive restructuring, relaxation training, and modifications to the child’s environment (Tolin et al., 2009). Three out of the four adolescents presented meaningful improvement in attendance and re-entered the public school system, but at follow-up were reported to be in alternative education plans (Tolin et al., 2009). A noted difficulty with providing a functionally based treatment was disagreement of the child and parent regarding the function of school refusal behaviour. Disagreement between the child and their parent makes it more challenging to then select an appropriate intervention to address the function. A significant benefit of the daily CBT was related to homework completion (Tolin et al., 2009). Since CBT requires a large amount of homework, meeting with the adolescent and their parent in a 24-hour time frame from each homework assignment allowed quick elimination of problems with homework completion compared to waiting a week for the next session (Tolin et al., 2009). Although the primary goal of returning to school long-term was not achieved, three out of the four adolescents showed significant short-term success in school attendance, and parents reported that their children were successful in pursuing alternative educational programs (Tolin et al., 2009).

A functional model. According to Kearney, Pursell, and Alvarez (2001), children may refuse school for several reasons. To assist clinicians address a child’s school refusal behaviour, a functional analytic model was proposed by Kearney (2008), which relies on the reasons a child may refuse to attend school and categorized them into four domains:
(a) to avoid general school-related distress caused by known or unknown factors (b) to escape aversive social and/or evaluative situations at school (c) to pursue attention from significant others, such as parents and (d) to pursue tangible rewards outside of school.

(p. 11)

The first two functions refer to children refusing school to receive negative reinforcement, as the other two functions refer to children refusing school to receive positive reinforcement (Kearney et al., 2001). A strength of the functional model is that it applies to all children who are engaging in school refusal behaviour, and not only children who have anxiety-based concerns (Kearney et al., 2001). Implementing treatment that is based on reasons why a child may be refusing school can be very effective, however some children may not attend school for more than one reason, in which these complex cases often require an intensive, intricate, and innovative intervention (Kearney et al., 2001).

Kearney et al. (2001) presented two cases for children who engaged in complex school refusal behavior. These children did not attend school for both negative and positive reinforcement, as they were distressed about school, but enjoyed staying at home to be with their parents during the school day. Both participants were referred for school refusal behaviour categorized as acute (Kearney et al., 2001). Prior to implementing a specific treatment plan, the children and their parents were asked to complete the School Refusal Assessment Scale (Kearney, 2008) in order to measure the types and strength of the functions for school nonattendance (Kearney et al., 2001). Participant 1’s treatment was proposed to be a combination of contingency management training for parents combined with anxiety management, while participant 2’s treatment was proposed to be a combination of school-based accommodations, management of anxiety, and contingency management training for parents (Kearney et al., 2001). The treatment plan for participant 1 was to provide education surrounding the nature of the anxiety, address aversive situations at school and develop a hierarchy, reintegration back to the school environment through exposure, and building somatic management skills (Kearney et al., 2001). The treatment plan for participant 2 was to gradually reintroduce the classroom setting, address anxiety concerns, and engage with peers for support and potential tutoring to address academic problems (Kearney et al., 2001). Results indicated that participant 1 missed four days of school, but for legitimate and excused reasons, and learned new strategies to cope with changes that occurred within the classroom setting, reported by both the teacher and parents (Kearney et al., 2001). Results indicated that participant 2 continued to improve surrounding general distress; however, the parents reported more overall issues relating to dealing with their son, but these concerns were not reflected in daily attendance (Kearney et al., 2001). Kearney et al. (2001) conclude that since school refusal behaviour is a complex issue, it is critical for both the parents and the clinician to establish a positive relationship with school staff. This includes frequent and effective communication, as assistance from school professionals is important for the child’s reintegration back to the classroom.

Kearney (2007) states that determining the function of a child’s school refusal behaviour is likely connected to important decisions regarding choice of intervention. The aim of his study was to further examine the functional model in addressing school refusal (Kearney, 2007). A total of 222 youths who engaged in school refusal behaviour and their parents were referred to a specialized outpatient clinic based in a university (Kearney, 2007). Child and parent self-report measures of behaviour and its functions were administered (Kearney, 2007). Addressing the function of school avoidance behaviour is useful to examine the forms of the behaviour contributing to the degree of a child’s nonattendance (Kearney, 2007). Results indicated that
assessing the functions of nonattendance did provide a greater understanding of the school refusal behaviour (Kearney, 2007). This study provided additional evidence for using a functional model for clinicians to consider the reinforcer of the behaviour, either positive and/or negative, as these reinforcers are more stable than forms of behaviour that are continuously changing (Kearney, 2007). Lastly, Kearney (2007) adds that most children will adjust their behaviour either on a daily or weekly basis when attempting to miss school, but the primary reason for nonattendance does often remain consistent.

According to Kearney and Silverman (1999), the treatment validity of the School Refusal Assessment Scale (SRAS) and the functional analytic model are favorable. The SRAS is a measure specifically used for children and/or adolescents with problematic school avoidance behaviour (Haight, Kearney, Hendron, & Schafer, 2001). The SRAS is a 24-item measure of the strength of the four functions of school refusal in which six items are given to each function (Haight et al., 2001). This measure is used as part of a comprehensive functional assessment to assist clinicians in creating a profile of factors maintaining school refusal behavior. The results from this assessment are then used to facilitate treatment direction (Haight et al., 2001). A study by Kearney and Silverman (1999) examined the utility of the functional model and the SRAS to address the effectiveness of prescriptively assigned treatment compared to non-prescriptively assigned treatment for eight children who display school refusal behaviour. Prescriptive treatment refers to treatment adapted from the highest-rated functional domain from the SRAS, and non-prescriptive treatment refers to treatment adapted from the lowest-rated functional domain from the SRAS (Kearney & Silverman, 1999). Four participants received prescriptive treatment based on mean scores from the SRAS, and four participants initially received non-prescriptive treatment; however, as the study continued, all participants received the prescriptive treatment (Kearney & Silverman, 1999). Similar to Kearney (2007), results concluded that ratings produced from the SRAS are helpful for predicting the effectiveness of a treatment for an individual child, as the non-prescriptive treatment from the SRAS was not successful for reducing school refusal for the four participants (Kearney & Silverman, 1999). The non-prescriptive treatment led to the worsening of a child’s anxiety and percentage of nonattendance (Kearney & Silverman, 1999). In addition to using a functional model, Kearney and Silverman (1999) propose that methods including behavioural observation should be used as an addition to the SRAS ratings to provide a more descriptive picture of the function for nonattendance. Following a functional assessment it is critical to include the collaboration between multiple professionals in order to effectively address school refusal behaviour.

A Collaborative Approach

Gittell, Godfrey, and Thistlethwaite (2013) state that interprofessional collaborative methods occur when multiple service workers from a variety of professional backgrounds work alongside families, patients, and the community to deliver the greatest quality of care. Interprofessional collaboration allows workers in the health field to invite professionals from other areas of work and present skills and information that will help achieve a common goal for an individual client (Gittell et al., 2013). The basis of interprofessional collaboration is focused on learning about, from, and with other workers to enable practitioners to work more effectively together as a team or collaborative group (Gittell et al., 2013). According to Craven and Bland (2006), in order for collaboration to be successful it is importation to consider the preparation, time, and support, by building upon clinical relationships that already exist.
Relational coordination is another way to improve quality healthcare relationships, as it also focuses on sharing respect and communication (Gittell et al., 2013). Both interprofessional collaboration and relational coordination emphasize the importance of building shared goals, knowledge, and respect across professional boundaries (Gittell et al., 2013). According to Gittell et al. (2013), the greater amount of relational coordination produces greater quality and efficiency during performance with fewer missed opportunities and less wasted effort, as well as improving job satisfaction and social support when stressed. Evidence has shown that relational coordination between healthcare providers facilitates enhanced relationships with patients and family members (Gittell et al., 2013).

According to Craven and Bland (2006), improved services in collaborative mental health care have begun to emerge. Kearney (2008) states that professionals must develop shared assessment strategies that thoroughly consider child, family, school, peer, and community factors. In addition, these individuals must come together to develop effective techniques to address school refusal behaviour and the pertinent risk factors involved (Kearney, 2008). In a study by Tolin et al. (2009), they concluded that a very useful aspect of their program was incorporating a multidisciplinary approach between educational and clinical specialists. As the clinical psychologist implemented therapy for the child and their parents, the school staff were able to discuss recommendations for modifications when delivered in the school, and served as the primary individual for communication with other school officials (Tolin et al., 2009). Since providing treatment for school refusal behaviour is considered complex and challenging, the use of a multidisciplinary approach is proposed to be a critical addition to common practice (Tolin et al., 2009). In addition to a multidisciplinary approach, involvement of a child and/or adolescent’s parents can also improve treatment outcome.

Parent Involvement

Parents may unintentionally contribute to the prolongation of their child’s anxiety by using anxious self-talk and displaying avoidance behaviour (Kendall et al., 2016). More specifically, parents may also feel inadequate in being able to manage their child’s school refusal behaviour and may be unable to assist in facilitating school attendance. Providing training for parents is considered to be a meaningful component when addressing anxiety in youth (Kendall et al., 2016). The anxiety a child experiences may decrease by providing psychoeducation to parents to eliminate their anxious self-talk and assisting parents to model behaviours that are brave, compared to avoidant behaviours (Kendall et al., 2016). Important responsibilities of parents according to Pereira et al. (2016), include being a facilitator outside of clinical sessions to monitor their child’s behaviour, to assist in applying the new skills learned in session, carry out exposure plans, and to support the completion of homework activities. Pereira et al. (2016) stated that greater levels of parent attendance and involvement during sessions are commonly predictive of more effective treatment outcomes for the child.

The study conducted by Pereira et al. (2016) explored the degree of parent involvement, as well as considering their involvement during in-session and out-session responsibilities. In-session responsibilities included attendance and communication with the clinician and out-session responsibilities included support for exposure activities and homework completion (Pereira et al., 2016). Fifty children and their parents participated in The FRIENDS for Life Program, which is a group CBT intervention to assist children to learn coping strategies, receive psychoeducation, engage in exposure and cognitive restructuring activities, and complete homework in-between sessions (Pereira et al., 2016). Parents also received summaries of the
content and homework from each session, and were given the opportunity to participate in two parent sessions (Pereira et al., 2016). Results indicated that parents’ general level of involvement in therapy was moderate, with in-session involvement being significantly higher compared to out-session involvement (Pereira et al., 2016). Explanations for this could have been parents with busy schedules, having limited time to support their child and/or accommodating their child’s anxiety because they found it bothersome to expose their child to aversive situations (Pereira et al., 2016). Greater parent involvement often predicts a decrease in symptoms of anxiety; therefore, parent participation is crucial when implementing CBT for children (Pereira et al., 2016). Lastly, Pereira et al. (2016) emphasized that parents are valuable assets during exposure especially, with helping create the hierarchy, supporting the exposure activities, and rewarding their child’s attempts.

Silverman, Kurtines, Jaccard, and Pina (2009) stated that parents play a critical role in either alleviating or contributing to their child’s level of anxiety. Silverman et al. (2009) conducted a study to examine the dynamics between a child’s anxiety and parental variables by comparing CBT with low parent involvement to CBT with consistent parent involvement for youths with anxiety. The CBT condition targeted anxious symptomology through individual sessions where parent participation was minimal, while the CBT/P condition also targeted anxious symptomology, but through sessions with youth and parent involvement with the therapist. The intervention strategies were the same for both conditions including, but not limited to, exposure to aversive situations, behavioural strategies, handouts, and homework activities. However, the parent condition included targeting positive and negative behaviours towards their child, relationship conflict, and parental anxiety if needed, as well as feedback for next session’s assignments and planning exposure activities. Results indicated that whether parents were or were not involved, anxiety was reduced in both conditions (Silverman et al., 2009). During the intervention, Silverman et al. (2009) concluded that changes in the youth’s anxiety also produced changes in their parent’s anxiety symptomology, as well as a decrease in negative parenting behaviours. As parent involvement is important for teaching new skills to their child, student practicum also allows for involvement of multiple professionals to teach skills from an agency supervisor to the child in session.

**Student Practicum**

Simons et al. (2012) state that practicum provides students fieldwork in social service agencies in order to apply learned psychological theory to services provided by community agencies. A major strength of practicums include integration of theory to increase student’s knowledge of behavioural modification skills and psychosocial interventions (Simons et al., 2012). Student practicum enhances personal development (discipline-related knowledge), interpersonal development (communication skills), civic development (social responsibility), and professional (career-related interests) development (Simons et al., 2012). Practicum allows students to apply real-world experiences to the class content and to apply this knowledge to generate informed decisions related to their future career, as well as involvement in consistent learning, professional development, and critical reflection (Simons et al., 2012). In addition, students often improve their communication and time management skills, and increase their confidence and responsibility during participation in a placement (Simons et al., 2012). The length of time students dedicate to placement in a community-based agency is related to a larger understanding of concerns and commitment to service for the welfare of the community (Simons et al., 2012).
Simons and colleagues (2012) conducted a pilot study of 38-college students and 31 field supervisors’ learning outcomes during an undergraduate psychology practicum. Placement sites included mental health centers, rehabilitation centers, alcohol and/or drug counselling centers, educational settings, etc., where students utilized their helping skills and applied their understanding of psychological principles into practice (Simons et al., 2012). At the end of the practicum, all students reported a greater understanding of psychological content, in which they connected their placement to psychological theories (Simons et al., 2012). In addition, students acquired terminology related to their career of interest, the responsibilities of a professional role, improved time management, and were more prepared to enter the working environment and/or apply to graduate school (Simons et al., 2012). The field supervisors added that students worked well and were able to develop rapport with clients, were dependable and responsible, and were likely to be hired following practicum (Simons et al., 2012). Lastly, the students stated that interacting with clients and watching client personal goals be achieved were the best component of the practicum (Simons et al., 2012).

According to Simons et al. (2012), all students should gain as much experience as they can in order to trust their clinical judgment and develop their professional character. An effective way to strengthen university-community partnerships is to build and sustain relationships with local service agencies and organizations to expand the university community (Simons et al., 2012).

Gaps in the Literature

The first identified gap in the literature is implementing CBT for children with anxiety in a school environment (Chiu et al., 2013). There is recognized effectiveness of CBT for children with anxiety in general, but there is limited knowledge regarding CBT application when delivered outside of a clinical setting, such as a school (Chiu et al., 2013). Although school settings are in a critical position to identify child mental health concerns, evidence-based treatment have been relatively slow to transfer from research settings to a school environment (Chiu et al., 2013). Secondly, experiential studies regarding a collaborative approach between multiple professionals are relatively scarce (Craven & Bland, 2006). An important and understudied area is evaluating interventions developed to enhance collaboration between local primary care workers and mental health services (Craven & Bland, 2006). Lastly, there are limited studies that have systematically examined the significance of practicum on undergraduate students and the clients those students are working with. Most studies focus on descriptive targets of practicum experiences and/or how practicum may help students learning goals (Simons et al., 2012). More research is recommended to understand the influence of experiential learning on student professional development (Simons et al., 2012).

Relationship Between the Literature and the Research Study

The findings in the literature emphasize the use of CBT interventions for children and/or adolescents with mental health concerns, such as anxiety disorders. In addition, the research reviewed above, suggests a need for incorporating the use of a functional model, a collaborative approach, and parent involvement in conjunction with CBT programs. In this study, the functional model is used to determine an appropriate intervention suited to meet each child’s specific needs. A collaborative approach between multiple professionals is utilized to communicate critical information about each child and determine a suitable treatment approach. In addition, a workshop is provided to the parents of the children and/or adolescents involved in
the project to introduce behavioural strategies and coping skills to practice as a family. CBT is comprised of many concepts and applications that are evidence-based. The treatment protocols delivered to the participants in this project are a traditional and modified CBT approach. The literature reviewed involved child and adolescent participants, which correlates with the age group of participants in this current study. The literature also represents an age group that will most likely benefit from a CBT program, as there is ample amount of evidence that stresses the need for early intervention in children and adolescents. In conclusion, the current study aims to increase school attendance among children and adolescents and decrease their mental health symptomology, in a population, that appears to need it most.
Participants and Selection Procedures

This study included two participants who displayed school refusal behaviour. Inclusion criteria included students between grades four and eleven selected by their school attendance counsellor of Ontario School Boards based on the need for treatment to increase the students’ daily attendance and decrease mental health symptomatology. Exclusion criteria included any child and/or youth who posed a threat to either themselves or others, as a result of aggressive behaviour. In addition, any students who were outside of the city (20 kilometers or more) were excluded from this study. The attendance counsellors contacted the students’ families to provide an overview of the project and inquire as to the families’ interest in participating in the project. The referrals were forwarded to clinicians at the hospital with the consent of the parent/guardian. The clinicians at the hospital contacted the families to arrange an initial intake assessment, gather background information, and provide further details regarding the project.

**Participant 1.** Participant 1 was a 15-year-old female referred for school refusal behaviour. There was no formal diagnosis of any mental health concerns. For this participant, school refusal behaviour began during the second semester of the prior school year. At the time of her intake assessment, she had missed every day since the beginning of this school year. She reported that she becomes anxious when other people have expectations of her and feelings of discouragement if she cannot meet these expectations. She also expressed concern regarding being around groups of students at the school. In addition, she experienced unpleasant somatic symptoms such as stomachaches and numbness during the school day. She also expressed concern that the workload of in-class and online courses was too difficult for her. On a regular basis, she would not walk into the school building. Instead, she would sit in the vehicle outside of the school building with her father and siblings. Her siblings would enter the school building, but she would refuse to enter and would then be brought back home.

**Participant 2.** Participant 2 was a 10-year-old male referred for school avoidance behaviour. He had a formal diagnosis of ADHD, Anxiety, and a Mood Disorder. His initial referral was based on the previous school year attendance concern where he was absent for a total of 28 full school days. For this participant, school refusal began at the home prior to school where he would yell and cry as stated by his mother. This continued upon arrival to the school each morning, where tantrums occurred in the vehicle. At the time of his intake assessment, he had been attending school on a full-time basis; therefore, a relapse prevention approach was used. He reported anxiety surrounding what he thought other students were thinking of him and expressed concern that the workload in some subject areas was too difficult for him. He displayed disruptive behaviour problems in the classroom, which negatively impacted his success at school. Disruptive behaviour included frequent anger outbursts of yelling and on occasion he would become emotionally escalated to the point he would leave school property without notice.

**Parent workshop.** Three parents of other children and/or youth in the School Attendance Project participated in the parent workshop. The parents included were not parents of either participant 1 or 2. Although they were given the opportunity to attend the parent training sessions, they declined due to previous weekly commitments. This workshop provided further information regarding mental health concerns, school refusal behaviour, and CBT techniques to help facilitate a regular pattern of attendance and/or address behavioural concerns if necessary. Further information regarding the parent workshop can be found in Appendix G.


Informed Consent

The St. Lawrence College and Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Boards approved this research study, including the consent and assent procedures, prior to the beginning of the study. Consent and assent were acquired during the intake assessment. Parents of the selected participants received the written consent form (Appendix A) to provide consent for their child’s participation in the project. The student researcher described the aim of the project, the intervention procedures, and how to withdraw participation if necessary. To obtain verbal assent from the selected youth the student researcher described the overall goals and procedures of the intervention by using a written script at the youth’s level of understanding (see Appendix B). Lastly, Parents also received a separate consent form (Appendix C) to provide consent for participation in psychoeducation sessions to increase their understanding of school avoidance, mental health concerns, and strategies to facilitate their child’s school attendance. The student researcher outlined the project, the psychoeducation sessions, and their rights if selected to participate.

Research Design

The current study utilized a pre- and post-test design. Pre-test included data collection from standardized assessment measures and behavioural observation in Participant 2’s school, which included observing behaviour in the classroom and at recess, as well as observing his interaction with peers to provide a greater understanding of the overall concern. Following this condition, an individualized treatment program created by the student researcher was developed and implemented for each participant. The independent variable consisted of psychoeducation and the application of CBT techniques based on a functional model approach. The dependent variables were school attendance and mental health symptomology. Psychoeducation and CBT techniques were provided with the expectation of positively influencing school attendance and mental health symptomology. Post measures included data collection to determine pattern of attendance and symptom severity. The data collected throughout this study, baseline and intervention, was presented using a line graph to display each participant’s school attendance. Pre- and post-measures of mental health symptomology presented using a bar graph and total scores are compared. Percentage of data points exceeding the median (PEM) will be calculated to determine any differences between baseline and intervention. This method of visual analysis was chosen as it represents the increasing and/or decreasing trends in the data comprehensively.

Setting and Materials

The study occurred both at the hospital and at one of the participant’s school. The intake assessment for both participants was conducted at the hospital. During the first week of intervention, the student researcher met Participant 1 three times at the school for support and to facilitate entry into the building. Following the first week, the setting for Participant 1’s sessions occurred at the hospital. The setting for Participant 2’s sessions occurred at his school. The psychoeducation sessions for the parents were held at the hospital. Materials included Adolescent Anxiety CBT and SCT Participant Manual (Blaney, McIvor, & Pike, 2016), CBT worksheets and diagrams from the manual mentioned, a workbook adapted from AnxietyBC (Bilsker, Samra, & Goldner, 2009) created by the student researcher, and a binder for each participant to store their materials from each session for future reference. Materials for parent sessions included PowerPoint slides, a projector, worksheets, and folders for parents to store their materials.
Measures

Prior to the intake session, the student researcher obtained selected participants’ school attendance records from the attendance counsellors to utilize as a baseline measure of current pattern of attendance. During the intake sessions for the School Attendance Project, participants completed multiple assessment measures to obtain data surrounding the function of their school avoidance behaviour and their mental health symptomology. Assessments included The Beck Youth Inventory – Second Edition (BYI-II), The Self-Compassion Scale, and The School Refusal Assessment Scale – Revised – Child Version (SRAS-R-C). Parents of the selected participants also completed The School Refusal Assessment Scale – Parent Version (SRAS-P) in order to corroborate the information collected from the SRAS-R-C (Beck, Beck, Jolly, & Steer, 2005; Neff, 2003; Kearney, 2008).

The BYI-II is an assessment measure that is composed of five subscales to obtain self-report data: Anger (BANI-Y), Anxiety (BAI-Y), Depression, (BDI-Y), Disruptive Behaviour (BDBI-Y), and Self-Concept (BSCI-Y) (Beck, Beck, Jolly, & Steer, 2005). Each subscale is 20 items in length, totaling 100 items on the measure. Responses to each question are rated on a 4-point Likert scale from 0 (never) to 3 (always). For the scales that measure depression, anxiety, anger, and disruptive behaviour, the clinical range is for T-scores of 70 and above. For the measure of self-concept, the clinical range is for T-scores below 40. This measure produces ratings of constructs that are relevant to mental health concerns that may interfere with an individual’s pattern of attendance; therefore, this assessment was suitable in measuring pre- and post-treatment levels of internalizing and externalizing behaviours. The overall measures of reliability are slightly stronger for adolescents, which reflect their higher capabilities in responding to questions compared to younger children (Beck, 2005). Validity is also established in this measure as correlations among the subscales are substantial and in the expected directions (Beck, 2005). Additionally, there is evidence of construct validity due to this measure’s relationships with other related instruments (Beck, 2005). Lastly, evidence of discriminant validity is provided through group separation as the inventories can distinguish groups (Beck, 2005). This measure was not included in an appendix due to copyright laws.

The Self-Compassion Scale (Appendix D) is an assessment measure that consists of six subscales: Self-kindness, Self-judgment, Common humanity, Isolation, Mindfulness, and Over-identification (Neff, 2003). There are 26 items in length and responses to each question are rated on a 5-point Likert scale from 1 (almost never) to 5 (almost always). Average overall self-compassion scores are relatively around 3.0 on the 1-5 scale; therefore, a score of 1-2.5 for overall self-compassion indicates low self-compassion, 2.5-3.5 indicates moderate self-compassion, and 3.5-5.0 indicates high self-compassion. Since mental health concerns most commonly involve negative behaviours and self-perception of oneself, this assessment was suitable in providing pre- and post-treatment measures of the individual tendencies of one of the participants.

The SRAS-R child and parent versions (Appendix E and F) are assessments designed to measure the function of each participant’s school refusal behaviour (Kearney, 2008). The four functions measured on the scale are Avoidance, Escape, Attention, and Tangible. Each function is six items in length, totaling 24 items on the measure. Responses to each question are rated on a 7-point Likert scale from 0 (never) to 6 (always). These assessments were selected, as they provide background information surrounding the functions that maintain an individual’s school avoidance behavior and assist in providing further insight for the type of treatment approach to be implemented.
Procedures

**Participant 1.** When consent forms were returned, individual CBT sessions with the student researcher began at the hospital. These sessions followed the *Adolescent Anxiety CBT and SCT Participant Manual* (Blaney, McIvor, & Pike, 2016). This manual was not included in an appendix due to copyright laws. An outline of each session including activities and worksheets used is provided in Appendix G. Each session was conducted for one hour twice a week. These 6 structured sessions consisted of the following concepts:

**Session 1.** This session involved establishing rapport with the client and building a collaborative therapeutic relationship. The client then completed the assessment measures above. The student researcher assisted the client to identify maladaptive cognitions and behaviours. The student researcher delivered the rationale of the CBT Model and used illustrations based on the client’s experiences. The cognitive strategy used was guided discovery to identify the causes and maintenance of anxiety and the importance of developing alternative coping strategies and developing goals. Homework was assigned to extend the client’s efforts beyond the sessions. The behavioural strategy assigned was breathing exercises to reduce levels of automatic arousal created by anxiety.

**Session 2.** This session involved mutually agreed goal setting where the student researcher and the client prioritized goals to be completed during the therapy time period (SMART Goal). The student researcher and client created a hierarchy of goals and one was selected. The behavioural strategy used was graded task assignment by discussing the importance of small steps towards the goal and developing behavioural challenges to overcome anxiety-provoking situations. The behavioural strategy assigned for homework was progressive relaxation training.

**Session 3.** This session involved the importance of targeting dysfunctional assumptions and tracking mood. The student researcher and the client discussed thinking errors and learning to recognize errors in patterns of thinking. The student researcher introduced a thought record to the client and noting the importance of keeping track of positive events as well as anxiety-provoking events. The behavioural strategy assigned for homework was a behavioural experiment, which was completed the first step in achieving the client’s SMART Goal. The cognitive strategy assigned for homework was to complete a thought record for the week.

**Session 4.** This session continued collaborative work around challenging negative automatic thoughts using a worksheet of a type of thought challenge. The student researcher and the client completed the thought challenge together and the client was then given one for homework to practice. The behavioural strategies assigned for homework was to complete a behavioural experiment, a thought challenge, and controlled breathing exercises.

**Session 5.** This session continued collaborative work around challenging negative automatic thoughts using a worksheet of a different type of thought challenge from the previous session to determine which type of technique suited the client best. The student researcher and the client completed the thought challenge together and the client was given one for homework. The behavioural strategies assigned for homework was the same as previous session.

**Session 6.** This session was the final session of therapy with the student researcher. The client completed the assessments administered during the first session to evaluate client progress and treatment outcome. This session concluded by meeting with the
Psychologist to discuss future support through the hospital following termination of therapy with the student researcher.

**Participant 2.** When consent forms were returned, individual therapy sessions based on a modified CBT approach with the student researcher began at the participant’s school. These sessions followed the *Managing Anger Workbook* created by AnxietyBC (Bilskner, Samra, & Goldner, 2009). This workbook was not included in an appendix due to copyright laws. An outline of each session including activities and worksheets used is provided in Appendix G. Each session was conducted for one hour once a week. These 5 structured sessions consisted of the following concepts:

**Session 1.** This session involved establishing rapport with the client and building a collaborative therapeutic relationship. The client then completed the assessment measures above. The student researcher assisted the client to identify maladaptive cognitions and behaviours. The student researcher delivered the rationale of the modified approach of the CBT Model and illustrated this using the client’s experiences. The cognitive strategy used was guided discovery to identify the importance of managing anger. The student researcher and the client completed the first step in the workbook mentioned above: Selecting an Anger Situation. The behavioural strategy completed was a progressive muscle relaxation activity and the client was given a copy of this activity. The assigned homework was to practice the muscle relaxation activity to reinforce what was learned in the session.

**Session 2.** This session involved the importance of targeting dysfunctional assumptions. The student researcher and the client discussed how to recognize when thinking errors occur and completed the second step in the workbook: Identifying Anger Thoughts. The behavioural strategy completed was a controlled breathing exercise and the client was given a copy to practice outside of the session.

**Session 3.** This session involved collaborative work around recognizing how anger thoughts affect daily functioning, specifically in the school environment. The student researcher and the client completed a thought challenge verbally and completed the third step in the workbook: How Anger Thoughts Activate Angry Mood. The behavioural strategy used was the muscle relaxation activity from the first session, which the client was given to practice again for homework.

**Session 4.** This session continued collaborative work around challenging negative automatic thoughts using a different worksheet from the previous session. The student researcher and the client completed this worksheet and completed the fourth step in the workbook: Replacing Anger Thoughts with Calm and Helpful Ones. The cognitive strategy used was creating a positive data log called a “Calm Colors Palette”. The behavioural strategy used was the muscle relaxation activity from the previous session, which the client was given to practice.

**Session 5.** This session was the final session of therapy with the student researcher. The client completed the assessments administered during the first session to evaluate client progress and treatment outcome. This session concluded by creating stress balls for a physical relaxation technique for the client to use during the day. This technique was chosen because the ball was small in size and was not a distraction to the other students as it is an individual activity. The behavioural strategy used was the muscle relaxation activity from previous sessions. This session concluded by meeting with the school Vice
Principal to discuss future support through the school following termination of therapy with the student researcher.

**Parent workshop.** When consent forms were returned, psychoeducation group sessions led by the student researchers began at the hospital under clinical supervision of the Psychologist. Student researchers at the hospital created these sessions during their practicum based on previous parent group material used. The manual was not included in an appendix due to copyright laws. Each session was conducted for two hours once a week. The focus of the first session was to introduce parents to school refusal, the CBT model, stress behaviour vs. misbehaviour, and the fight/flight/freeze and relaxation responses. The focus of the second session was to introduce parents to the different between anxiety and fear, how to reduce intense emotions, cognitive distortions, and thought challenges. The focus of the third session was to introduce parents to self-regulation and self-care, ways to reduce stress individually and as a family, and using behavioural strategies to help support their child. The focus of the fourth session was for the parents to discuss previously used behavioural strategies, discussion surrounding learning challenges, introducing parents to ways to advocate for the child, and ways the child can advocate for oneself. Lastly, the fifth was the final psychoeducation session. This session focused on an overall review of the content covered in previous sessions and feedback surrounding the group, followed by the post-measure of parent confidence. A detailed outline of the content covered during each psychoeducation session can be located in Appendix G.

**Collaboration/clinical supervision.** Each month the student researchers, clinical and college supervisors, and attendance counsellors attended a scheduled meeting to discuss each participant, their progress, and any modifications to be made to their individualized programs. These meetings ensured that each professional’s perspective was taken into account in order for the participants to receive the most suitable intervention to meet their needs.
Chapter IV – Results

This aim of this study was to determine the functional variables maintaining each participant’s school refusal behavior using the SRAS-R-C, increase regular school attendance, and decrease mental health symptomology, as identified by scores on the BYI-II and SCS. Individualized programs based on the results of the mentioned measures were then implemented for each participant. Results are presented in order of each participant.

Participant 1

School refusal assessment scale – revised – child (SRAS-R-C). Participant 1 completed the SRAS-R-C on November 7, 2017, which was administered by the student researcher. She was instructed to circle the response that she felt most accurately fit each question. Figure 1 presents Participant 1’s mean scores for each function of school refusal behaviour. The scores for the SRAS-R-C were calculated using guidelines provided by Kearney (2008). Her score for the first function on the scale, avoidance of school-related stimuli that provokes negative affect was 5.16. Her scores for the second, third, and fourth functions were 2.16 (escape from aversive stimuli), 3.50 (attention-getting behaviour), and 1.50 (pursuit of tangible rewards outside of school). These results strongly indicated that Participant 1’s primary function of school refusal behaviour was avoidance of stimuli associated with the school. Raw data of these results can be found in Appendix H.

![Figure 1](image-url)  
*Figure 1. Graphical representation of Participant 1’s mean scores for each function of the SRAS-R-C.*

School refusal assessment scale – revised – parent (SRAS-R-P). The SRAS-R-P was sent home with Participant 1 for her father to complete on November 7, 2016, but was not returned.
Beck youth inventory – second edition (BYI-II). Participant 1 completed the BYI-II on November 7 and December 12, 2017, which was administered by the student researcher. She was instructed to circle the statement that was best representative of her thoughts, feelings, and behaviour in relation to the five subscales for the past two weeks. Figure 2 presents Participant 1’s T scores for each of the subscales in the BYI-II for both the pre and post measure assessment. Raw data, T scores for each subscale for both pre and post assessment, as well as scoring information, are included in Appendix H. The results demonstrated that Participant 1’s self-concept remained at an average level consistent from pretest (T= 47) to posttest (T= 49). Participant 1’s level of anxiety decreased from a moderately elevated level (T= 64) to an average level (T= 55). Additionally, her level of depressive symptoms also decreased from a moderately elevated level (T= 62) to a mildly elevated level (T= 58). Participant 1’s level of anger remained at an average level consistent from pretest (T= 53) to posttest (T= 48). Lastly, her level of disruptive behaviour decreased from a mildly elevated level (T= 55) to an average level (T= 48).

Figure 2. Graphical representation of Participant 1’s T scores for each subscales on the Beck Youth Inventory – Second Edition pre and post measure.

Self-compassion scale (SCS). Participant 1 completed the SCS on November 7 and December 12, 2017, which was administered by the student researcher. She was instructed to provide the rating that accurately described her behaviour towards herself during difficult times. Figure 3 presents Participant 1’s scores for each of the subscale items for both the pre and post measures. The mean scores for each of the subscale items for both the pre and post measures are included in Appendix H. Scores for the negative subscales, self-judgment, isolation, and over-identification were reverse scored, therefore; higher scores on these items are reflective of lower self-compassion. Self-compassion was calculated by adding the mean scores for self-kindness, common humanity, and mindfulness subscales and dividing by 3. Self-judgment was calculated
by adding the mean scores for self-judgment, isolation, and over-identification. The results demonstrated that Participant 1’s level of self-compassion decreased from pretest ($M = 4.24$) to posttest ($M = 3.82$) and level of self-judgment increased from pretest ($M = 2.43$) to posttest ($3.42$). Participant 1’s overall level of self-compassion remained consistent at a moderate level of self-compassion from pretest ($M = 3.34$) to posttest ($M = 3.32$).

**Figure 3.** Graphical representation of Participant 1’s mean scores for each subscale on the Self-Compassion Scale pre and post measure.

**Attendance record review.** Attendance records for the current school year (September to December 2017) were obtained through the attendance counsellor for this participant on December 15, 2017. Data on her attendance from these records are presented in a table in Appendix I. The percentage of weekly attendance was calculated by determining the number of school days Participant 1 attended each week and dividing by the total number of school days in the week. Attendance was counted if the participant attended the full school day. Figure 4 presents the percentage of days Participant 1 attended from September to the middle of December 2017. Participant 1’s mean attendance for this period of the school year was 17.14%. Participant 1’s attendance gradually increased from baseline to intervention. A graph with trend lines is included in Appendix I. Overall, 0% or 0 out of 15 data points fall within 25% of the median (i.e. between 14.00 and 18.00), which demonstrates that the data were not stable. The data represents an increasing trend and PEM at 71.43%. Since the PEM was between 70% and 90%, the intervention was considered to be effective.
Figure 4. Graphical representation of the percentage of days Participant 1 attended from September to the middle of December 2017.

Participant 2

School refusal assessment scale – revised – child (SRAS-R-C). Participant 2 completed the SRAS-R-C on November 2, 2017, which was administered by the student researcher. He was instructed to circle the response that he felt most accurately fit each question. Figure 5 presents Participant 2’s mean scores for each function of school refusal behaviour. The scores for the SRAS-R-C were calculated using guidelines provided by Kearney (2008). His score for the first function on the scale, avoidance of school-related stimuli that provokes negative affect was 3.00. His scores for the second, third, and fourth functions were 2.50 (escape from aversive stimuli), 4.50 (attention-getting behaviour), and 4.66 (pursuit of tangible rewards outside of school). These results strongly indicated that Participant 1’s primary function of school refusal behaviour was pursuing tangible rewards outside of the school environment, with a close secondary function of attention-getting behaviour. Raw data of these results can be found in Appendix H.
School refusal assessment scale – revised – parent (SRAS-R-P). The SRAS-R-P was given to Participant 2’s mother following the intake session to complete on October 26, 2017, but was not returned.

Beck youth inventory – second edition (BYI-II). Participant 2 completed the BYI-II on November 2, 2017 and December 12, 2017, which was administered by the student researcher. He was instructed to circle the statement that was best representative of his thoughts, feelings, and behaviour in relation to the five subscales for the past two weeks. Figure 6 presents Participant 2’s T scores for each of the subscales in the BYI-II for both pre and post measure assessment. Raw data, T scores for each subscale for both pre and post assessment, as well as scoring information are included in Appendix H. The results demonstrated that Participant 2’s level of self-concept remained at an average level consistent from pretest (T= 55) to posttest (T= 51). Participant 2’s level of anxiety decreased from a moderately elevated level (T= 61) to a mildly elevated level (T= 59). Additionally, his level of depressive symptoms also decreased from a moderately elevated level (T= 62) to an average level (T= 49). Participant 2’s level of anger decreased from a moderately elevated level (T= 60) to a mildly elevated level (T= 57). Lastly, his level of disruptive behaviour remained at an average level consistent from pretest (T= 51) to posttest (T= 51).
Attendance record review. Attendance records for the current school year (September to December 2017) were obtained through the attendance counsellor for this participant on December 15, 2017. Data on his attendance from these records are presented in a table in Appendix I. The percentage of weekly attendance was calculated by determining the number of school days Participant 2 attended each week and dividing by the total number of school days in the week. Attendance was counted if the participant attended the full school day. Figure 7 presents the percentage of days Participant 2 attended from September to the middle of December 2017. Participant 2’s mean attendance for this period of the school year was 90.00%. Participant 2’s attendance remained stable from baseline to intervention. A graph with a trend line is included in Appendix I. Overall, 26.6% or 4 out of 15 data points fall within 25% of the median (i.e. between 72.27 and 92.93), which demonstrates that the data were not stable. The data represents a stable trend and PEM at 71.43%. Since the PEM was between 70% and 90%, the intervention was considered to be effective.

Figure 6. Graphical representation of Participant 2’s T scores for each subscales on the Beck Youth Inventory – Second Edition pre and post measure.
Figure 7. Graphical representation of the percentage of days Participant 2 attended from September to the middle of December 2017.
Chapter V – Discussion

Participant 1

Data collected from the School Refusal Assessment Scale – Revised – Child showed that the primary function of school refusal behaviour was avoidance of stimuli associated with the school. This result was used to develop an intervention individualized to the participant’s needs, which proved to be effective as the CBT intervention was tailored to avoidance related behaviours. The participant’s program was effective in reducing avoidance behaviours associated with entering the school.

Data collected from the Beck Youth Inventory – 2nd Edition showed the cognitive behavioural therapy intervention to be clinically effective for Participant 1. The self-concept subscale showed the participant’s greater awareness of her self-concept. Her scores for the remaining subscales demonstrated that her anxiety, depressive symptoms, anger, and disruptive behaviour were less prominent following intervention. A potential increase in self-concept could be due to the sessions which focused on ways to recognize anxiety and depressive symptoms and a potential decrease in the remaining subscales could have been due to applying the strategies learned when symptoms of anxiety and depression were experienced. This was consistent with reports from the participant herself during sessions following anxiety awareness techniques. The client also reported a decrease in her avoidant behaviour relating to the school environment, which could also be attributed to learning coping skills during session.

In contrast, results from the Self Compassion Scale did not support the hypothesis of this research study. Although the cognitive behavioural therapy intervention proved to be clinically effective for increasing school attendance and decreasing mental health symptomology subscales on the BYI-II, scores from the Self Compassion scale did not show clinical improvement following intervention. Participant 1’s overall level of self-compassion decreased, while her level of self-judgment became more prominent following intervention. A potential reason for this result, as noted by the Psychologist, could be attributed to the fact that the participant’s gain in regular attendance decreased towards the last few weeks, specifically from Week 12-15, and therefore could potentially have led to more prominent self-judgment due to feelings of discouragement and failure.

Data collected on school attendance during intervention yielded positive results for both participants. For Participant 1, her percentage of school days attended did increase following intervention; however, attendance did decrease once again from Week 12 – 15. The increase in attendance could be attributed to the student researcher meeting the participant at the school in the morning on occasion and/or the participant regularly attending sessions at the hospital learning and practicing a variety of coping skills. A potential reason for the decrease in attendance was that the participant herself reported that during this time she was experiencing a heightened state of depressive symptoms than usual. This report was corroborated with the Psychologist’s notes in the file from the final session and the attendance counsellor’s observations. However, it is to be noted that an increase of depressive symptoms were not captured on the BDI scale.

Participant 2

Data collected from the School Refusal Assessment Scale – Revised – Child showed that the primary function of school refusal behaviour was pursuing tangible rewards outside of the school environment, with a secondary function of attention-getting behaviour. These results were
used to develop an intervention individualized to the participant’s needs, which proved to be effective as the modified CBT approach focusing on anger was tailored to reduce attention related behaviours, with a reinforcement component for participation during the session. The participant’s program was effective in increasing the use of coping skills when noticing anger situations.

Data collected from the Beck Youth Inventory – 2nd Edition showed the cognitive behavioural therapy intervention to be clinically effective. The self-concept subscale scores showed a greater awareness of the self following intervention. His scores for anxiety, depressive symptoms, and anger also proved to be less prominent following intervention; however, disruptive behaviour scores remained the same. A potential increase in self-concept could be attributed to the intervention awareness related activities. A decrease in the remaining subscales could be attributed to practicing a variety of new coping skills when the student researcher would visit the participant’s school. This was consistent with reports from the principal of the school and classroom teacher regarding an increase in appropriate behaviour during recess and academic work periods. According to the principal’s observations, disruptive behaviour may have remained stable due to conflict with other students in the classroom.

Participant 2’s percentage of school days attended remained at the same rate during intervention; however, attendance did decrease during Week 13. The same rate of regular attendance could be attributed to the student researcher visiting his school each week to teach and practice a variety of coping skills to prevent nonattendance similar to the previous school year. According to the participant’s school principal, nonattendance in Week 13 was due to illness. These results suggest that the intervention was effective in teaching the participant how to identify anxiety-provoking experiences and use the coping strategies learned during sessions to decrease feelings of anger and/or frustration.

**Interpretations of the Results**

It was hypothesized if the use of a functional model and CBT, with a collaborative approach between multiple professionals, would increase school attendance and decrease the severity of mental health symptoms among the selected youth. Results supported this hypothesis for both participants in this study. Consistent with Kearney (2007), the results of this research study found that assessing the function of a child’s nonattendance provided a greater understanding of the school refusal behaviour. In addition, the results from this study are consistent with the findings of Heyne et al. (2011) in that a CBT approach provided a clinically effective outcome for school refusal behaviour in order to promote school attendance and reduce some areas of mental health concerns. Similarly to the study conducted by Lundkvist-Houndoumadi et al. (2016), the results of this research study indicated that individualized case formulation allowed for intervention to be flexible in tailoring components of the treatment to address each child’s specific needs, in which mental health symptomology was decreased due to individualized therapy. Consistent with Chiu et al. (2013), the findings of this research study also concluded that a school setting may also be an effective setting to deliver a CBT intervention to address the impact mental health has on a student’s academic functioning and the coping skills learnt being generalized to multiple environments. Since school refusal behaviour is considered complex and challenging for treatment implementation, this study was consistent with the findings by Tolin et al. (2009), which indicate that the use of a multidisciplinary approach was a critical addition to standardized practice for effective outcome.
Strengths

Throughout the duration of the research study, specific beneficial areas were identified. The strengths of this study related to individualization, collaboration, and generalization.

CBT interventions allow for individual differences in comprehension and application. Since the interventions were based on the functional assessment, each session focused on a specific concern or need of the individual participant. There were also instances during sessions where the concept or strategy being taught was more difficult than previous ones. When this occurred, it was simple to adapt the information and emphasize certain concepts for a longer period of time than other concepts. In addition, teaching multiple strategies allowed for the participants to practice and determine which coping strategy worked best for them.

Another strength of this research study was the collaboration between multiple disciplines, for example the clinical and educational staff. The use of a collaborative approach allowed for communication between multiple disciplines to share background information relating to each participant, potential ideas for intervention, and follow-up plans for continuation of services following termination of student researcher involvement. Collaboration also included the child’s parents, who were also members of the intervention planning, but were not successful involved in the psychoeducation workshop.

Lastly, the coping strategies learned in each session appeared to be generalizable to multiple environments, although it was not specifically measured. Many of the coping strategies in CBT are relatively simple to complete when practiced, require minimal materials, and are not long in duration. This is relevant to the participants as many of these strategies could be used either at home or at school once mastered since they were learned in more than one environment (e.g. hospital and school support).

Limitations

Although there were noted strengths of this research study, some limitations were also identified which were related to time, parent involvement, and the targeted population.

The first limitation of this study was the time constraint. Since one of the participants’ intake session began later in the student placement, there were limited weeks remaining to implement an intervention to make a significant difference in the child’s life. Due to a time constraint the student researcher had to schedule sessions twice a week rather than once a week. This short time frame restricted the likelihood that this participant would significantly increase her attendance and decrease mental health symptomology; however, in some situations brief treatment may be beneficial.

Another limitation was the limited amount of parent involvement of the two participants. Although there was a parent workshop scheduled once a week for five weeks, neither of the participants’ parents attended any of the sessions. This suggests that an individualized approach for parents may also be needed. By not attending any of the sessions the parents were not able to support their children by learning similar coping skills and having a greater understanding of anxiety and school refusal behaviour through psychoeducation sessions.

Lastly, the targeted population (children with mental health concerns) as a whole is a difficult population to implement intervention with. A challenge for this population is attending all scheduled appointments either at the hospital or at the school. Since some of these children display symptoms of anxiety and use avoidance coping strategies to refuse attending school, the same was seen with attending scheduled hospital sessions. Furthermore, missed appointments decrease the overall intervention duration to implement a clinically effective intervention to
INCREASING SCHOOL ATTENDANCE

increase attendance and decrease mental health symptomology. This could have been measured by recording the number of appointments the client attended compared to the number of appointments that were missed.

**Multilevel Challenges**

Teaching coping skills to participants with mental health concerns is a complex task. With this, there are multiple challenges that occurred during the research study at the client level, program level, organizational level, and societal level.

**Client level.** The challenges that occurred at the client level were related to the participant and parent’s participation. As mentioned above, participants with anxiety are more likely to generalize their avoidant coping strategies to more than one environment, such as attending school and hospital sessions. The parents of the targeted population may also display this type of behaviour. Parents who have their own anxiety may find it more difficult to support their children and attend workshops for themselves possibly due to maladaptive coping strategies and increased fear.

**Program level.** The challenges related specifically to this research study included the students’ comprehension of the CBT program model and learning coping skills. In order for a child to be motivated to learn and practice CBT skills, the concepts of the technique need to be modified. This includes making activities more interesting and easier to understand based on the client’s level of functioning. When the participant was unable to understand the information, they were not motivated to practice the skills. This was a challenge because without practicing the skills, the likelihood of decreasing mental health symptomology is very low.

**Organizational level.** A challenge related to the organizational level was the effectiveness of the collaboration component. Although some collaboration occurred between the multiple disciplines, the meetings could have been more frequent to ensure information for each participant was recent and discussed as a group in order to make necessary modifications to the intervention, if needed. It is also important to include the parents and for all parties to share their opinion, evaluate the child’s progress, and select strategies to implement in different environments.

**Societal level.** The challenge related to this level was the approach commonly used in society for this population. In most agencies, when dealing with this population there is a lack of collaboration between agencies. Additionally, the funding assigned to a specific agency may be lacking, limiting the ability to collaborate with other agencies to provide the most effective care for the client. Another challenge at this level is that the services in these agencies are often based on a reactive approach rather than focusing more on prevention when mild mental health symptoms are presented and/or when a child first begins to display irregular attendance at school. In order for the clients to reach the best of their ability, it would be ideal for more agencies in the community to use a collaborative approach to providing services.

**Implications for the Behavioural Psychology Field**

This research study benefits the field of Behavioural Psychology and mental health disorders, as the outcome of the study demonstrated that individuals with mental health concerns could benefit from learning about the CBT model and coping strategies to increase regular school attendance and decrease mental health symptomology. In addition to the information depicted in the literature, the results suggest that behavioural approaches towards school refusal behaviour and CBT techniques may be clinically effective. Results from this study also provided
insight into the effectiveness of delivering mental health services through coordination between multiple professionals. This includes working together as one larger system to engage youth, their families, and service providers across the child and youth mental health system. This study also emphasizes the importance of early intervention in order to make a significant difference in a child’s life and eliminating missed opportunities for future achievement. By learning coping skills as a youth, one can generalize the behavioural strategies learned to adolescence and/or adulthood when experiencing anxiety during activities in daily functioning. This also applies to generalizing the behavioural strategies learned to multiple environments, making the coping skills learned applicable to a variety of situations and/or events.

**Recommendations for Future Research**

It is recommended that future research replicates the current research study. Firstly, this study should be duplicated with a larger sample size to validate the overall effectiveness of the School Attendance Project since this was the first trial following the pilot study. Secondly, a home component would be valuable to increase parent involvement if attendance in a group parent workshop is scarce. Increasing parent involvement and motivation during their child’s intervention would allow for teaching and practicing of coping skills in the home. This would also promote the opportunity for generalization to multiple environments when experiencing mental health symptomology. Not only would the children learn new coping skills, the parents could also use these strategies to combat their own mental health concerns and fears. Lastly, qualitative feedback from the participants about the overall interventions should be gathered to provide information on strengths and possible improvement based on their experience.
References


Appendix A
Parent Consent Form

St. Lawrence College
100 Portsmouth Ave.
Kingston, Ontario K7L 5A6

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

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

**Name of Supervisor:** Marie-Line Jobin, M.A., C. Psych. Assoc.

**Name of Institution:** St. Lawrence College

**Agency Supervisors:** Beverly Blaney, Cognitive Behavioural Therapist
Jennifer Davidson-Harden, Ph.D., C. Psych.

**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 of your child’s health and school records, and create a program that is based on cognitive-behavioural therapy techniques and the individual needs of your child. This will take place during a 14-week timeline, from
September to December, 2017, under joint supervision with the attendance counsellors from the school boards and the psychologist and psychotherapist. 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 fails, 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. At any time during the sessions, if your child shows any emotional distress the Behavioural Psychology students will notify the clinician and provide emotional support for your child.

**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 fictional name 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, such as the school board that they are enrolled in. Research data will be kept in the psychology testing library file, in a locked cabinet, at the hospital 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 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 or not 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 at a later time, it will have no impact on his/her treatment at the hospital. If you do decide for him/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 University Health Sciences and Affiliated Teaching Hospitals 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. We appreciate your cooperation. If you have any additional questions or concerns feel free to contact the following 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. You may also contact – Dr. Albert Clark, Chair of the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at the toll-free number: 1-844-535-2988 or clarkaf@queensu.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 at the hospital.
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 themself or others, they will report it to someone, withdraw my child from the program, and 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
Verbal Assent Script

Hello, my name is ___________ and I am a student too. Like you, I also have assignments and projects to work on, which can be difficult sometimes. Right now I am working on a project to help students like yourself to learn more about themselves and to make school more enjoyable. I will be working with ___________ and ___________ (agency supervisors), ______________ (attendance counsellor), and ______________ (college supervisor) as a team to help you go to school more often. This could include calling you in the morning, meeting you at your house or bus stop to walk to class with you, or meeting you at school to teach you skills or exercises. I would like to know if you want to help me with my project. If you choose not to take part, no one will be upset or angry with you. If you choose to take part but change your mind while we are working together this is also ok, just make sure that you let your parent or myself know as soon as possible. Do you have any questions about anything I just said? After hearing all of that, would you like to be part of my project?
Appendix C  
Psychoeducation Consent Form  

St. Lawrence College  
100 Portsmouth Ave.  
Kingston, Ontario K7L 5A6  

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

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


Name of Institution: St. Lawrence College  

Agency Supervisors: Beverley Blaney, Cognitive Behavioural Therapist  
Jennifer Davidson-Harden, Ph.D., C. Psych.  

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. We are currently on 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 psychoeducation workshops 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 workshops held at the hospital 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 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 to one of the students or supervisors, and/or remove yourself from the study.

**What happens if something goes wrong?**

Every individual within the psychoeducation 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, staff at the hospital, or the 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 at the hospital. Any computer files with data from the study will be kept on a password protected computer. All of the data within the study will be kept in the psychology testing library at the hospital 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 or not 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. 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 Health Sciences and Affiliated Teaching Hospitals 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. We appreciate your cooperation. If you have any additional questions or concerns feel free to contact the following 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. You may also contact – Dr. Albert Clark, Chair of the Queen’s University Health Sciences and Affiliated Teaching Hospitals Research Ethics Board at the toll-free number: 1-844-535-2988 or clarkaf@queensu.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 D

#### 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>Almost never</th>
<th>1</th>
<th>2</th>
<th>3</th>
<th>4</th>
<th>Almost always</th>
<th>5</th>
</tr>
</thead>
</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.
Appendix E
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>
</tr>
</thead>
<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>
</thead>
<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>

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>
<td>2</td>
<td>3</td>
<td>4</td>
<td>5</td>
<td>6</td>
</tr>
</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>
</tr>
</thead>
<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>

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>
<th>Always</th>
</tr>
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6. How often do you stay away from school because you feel embarrassed in front of other people at school?

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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?

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

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

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

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

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

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)?

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

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?

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

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?

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

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

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

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

Never  Seldom  Sometimes  Half the Time  Usually  Almost Always  Always
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17. If you had fewer bad feelings (for example, scared, nervous, sad) about school would it be easier for you to go?

Never  Seldom  Sometimes  Half the Time  Usually  Almost Always  Always
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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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**19. Would it be easier to go to school if your parents went with you?**

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**20. Would it be easier for you to go to school if you could do more things you like to do after hours (for example, being with friends)?**

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**21. How much more do you have bad feelings about school (for example, sad, nervous, scared) compared to other kids your age?**

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**22. How often do you stay away from people at school compared to other kids your age?**

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**23. Would you like to be home with your parents more than other kids your age would?**

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**24. Would you rather be doing fun things outside of school more than most kids your age?**

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**Total Score:**

**Mean Score:**

**Relative Ranking:**
Appendix F
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
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?

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

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

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

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

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)?

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

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?

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

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

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

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

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

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

Never  Seldom  Sometimes  Half the Time  Usually  Almost Always  Always
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### Appendix G

**Sessional Topic Breakdown – Participant 1, 2, and Parent Workshop**

#### Table 1

**Sessional Topic Breakdown – Participant 1**

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<thead>
<tr>
<th>Session</th>
<th>Content/Topics</th>
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</table>
| 1       | **Assessment:** Beck Youth Inventory – Second Edition (BYI-II), Self-Compassion Scale, and the SRAS  
          Introduced CBT Model  
          Discussed “Why I Get Anxious” handout  
          Explained physical manifestations of anxiety using “Body Map” handout and “Automatic Nervous System” diagram  
          Explained importance of goal setting using “SMART Goals” handout  
          Homework: Deep Breathing from website, “Achievement Award” handout, “My Life 5 Years From Now” handout, and 2 potential goals for treatment |
| 2       | Discussed principles of goal setting – behavioural challenges  
          Rated goals using “My Anxiety Group Goals” handout  
          Introduced “Small Steps” handout and the importance of breaking down goals  
          Completed “Steps to Completing Goal” handout for one goal  
          Homework: Continue Deep Breathing and/or try Body Scan from website, attempt behavioural challenge set, complete “Steps to Completing Goal” for one additional goal |
| 3       | Discussed progress on behavioural goal and anxiety rating  
          Set new behavioural challenge for the week and anticipated anxiety rating  
          Introduced, discussed importance, and completed “Single Incident Records” (SIRs) handout  
          Homework: Continue practicing coping skills, try Guided Meditation from website, complete SIR for 3 events, continue attempting behavioural challenges set |
| 4       | Discussed progress on behavioural goal and anxiety rating  
          Reviewed and discuss SIR from previous week  
          Set new behavioural challenge for the week and anticipated anxiety rating  
          Introduced and explained thinking errors using “Checklist of Thinking Errors” handout  
          Identified thinking errors using “Can You Identify the Thinking Error?” handout  
          Introduced mood record – Status Update and complete an example  
          Homework: Continue practicing coping skills and relaxation recordings as needed, complete 2 Status Update entries per day and identify the thinking error(s), attempt behavioural challenge set |
| 5       | Discussed progress on behavioural goal and anxiety rating |
Reviewed and discussed mood records from previous week
Introduced and discussed “Mood Record Errors” handout
Set new behavioural challenge for the week and anticipated anxiety rating
Introduced challenges to thinking errors using “Examine the Evidence” handout
Homework: Continue practicing coping skills and relaxation recordings as needed, complete 2 Status Update entries per day and identify the thinking error(s), complete Examine the Evidence for 2 situations, attempt behavioural challenge set

6 Assessment: Beck Youth Inventory – Second Edition (BYI – II) and Self Compassion Scale
Table 2

Sessional Topic Breakdown – Participant 2

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<tr>
<td>1</td>
<td><strong>Assessment:</strong> Beck Youth Inventory – Second Edition (BYI-II) and the SRAS&lt;br&gt;Introduced and discussed the importance of managing anger – how it can help/hurt us&lt;br&gt;Discussed how excessive anger can interfere with our life&lt;br&gt;Introduced Anger Thoughts Model&lt;br&gt;Introduced and discussed steps to managing anger&lt;br&gt;Completed Step 1 – “Select an Anger Situation” handout&lt;br&gt;Muscle Stretch Activity</td>
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<td>2</td>
<td>Introduced and discussed “Types of Anger Thoughts” handout&lt;br&gt;Introduced and discussed “More Realistic Thoughts” handout&lt;br&gt; Completed Step 2 – “Identify Anger Thoughts” handout&lt;br&gt;Completed “Can you guess the thought?” handout</td>
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<td>3</td>
<td>Discussed the importance of recognizing how Anger Thoughts can activate an Angry Mood&lt;br&gt;Discussed the importance of recording thoughts and discovering where they come from&lt;br&gt;Completed Step 3 – “Recognize How Anger Thoughts Activate Angry Mood” handout&lt;br&gt;Anger Dragon Story and Worksheet</td>
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<tr>
<td>4</td>
<td>Introduced importance of calming and helpful thoughts and discuss example&lt;br&gt;Completed Step 4 – “Replace Anger Thoughts with Calming and Helpful Ones” handout&lt;br&gt;Muscle Stretch Activity&lt;br&gt;Created Calm Colors Palette</td>
</tr>
<tr>
<td>5</td>
<td><strong>Assessment:</strong> Beck Youth Inventory – Second Edition (BYI-II)&lt;br&gt;Completed Step 5 – “Practice Calming and Helpful Thinking” handout&lt;br&gt;Introduced and created coping cards&lt;br&gt;Created stress ball&lt;br&gt;Muscle Stretch Activity</td>
</tr>
</tbody>
</table>
Table 3

*Sessional Topic Breakdown – Parent Workshop*

<table>
<thead>
<tr>
<th>Session</th>
<th>Content/Topics</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>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. misbehaviour 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.</td>
</tr>
<tr>
<td>2</td>
<td>Introduced difference between anxiety and fear, and when anxiety is problematic. Discussed labeling 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.</td>
</tr>
<tr>
<td>3</td>
<td>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.</td>
</tr>
<tr>
<td>4</td>
<td>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. Provided strategies to advocate for children, and examples of assertive statements to teach children self-advocacy.</td>
</tr>
<tr>
<td>5</td>
<td>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.</td>
</tr>
</tbody>
</table>
Appendix H
Pre-and-Post Measure Results – Participant 1 and 2

Results of Pre-and-Post Measures – Participant 1

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pre</th>
<th>Post</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>BYI-II</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Raw Score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSCI</td>
<td>38</td>
<td>40</td>
<td>+2</td>
</tr>
<tr>
<td>BAI</td>
<td>28</td>
<td>20</td>
<td>−8</td>
</tr>
<tr>
<td>BDI</td>
<td>24</td>
<td>20</td>
<td>−4</td>
</tr>
<tr>
<td>BANI</td>
<td>17</td>
<td>12</td>
<td>−5</td>
</tr>
<tr>
<td>BDBI</td>
<td>9</td>
<td>5</td>
<td>−4</td>
</tr>
<tr>
<td>(T-Score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSCI</td>
<td>47</td>
<td>49</td>
<td>+2</td>
</tr>
<tr>
<td>BAI</td>
<td>64</td>
<td>55</td>
<td>−9</td>
</tr>
<tr>
<td>BDI</td>
<td>62</td>
<td>58</td>
<td>−4</td>
</tr>
<tr>
<td>BANI</td>
<td>53</td>
<td>48</td>
<td>−5</td>
</tr>
<tr>
<td>BDBI</td>
<td>55</td>
<td>48</td>
<td>−7</td>
</tr>
<tr>
<td>SCS</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Self-Kindness</td>
<td>4.10</td>
<td>3.20</td>
<td>−0.90</td>
</tr>
<tr>
<td>Self-Judgment</td>
<td>2.30</td>
<td>3.00</td>
<td>+0.70*</td>
</tr>
<tr>
<td>Common Humanity</td>
<td>4.86</td>
<td>3.75</td>
<td>−1.11</td>
</tr>
<tr>
<td>Isolation</td>
<td>2.86</td>
<td>3.25</td>
<td>+0.39*</td>
</tr>
<tr>
<td>Mindfulness</td>
<td>3.75</td>
<td>4.50</td>
<td>+0.75</td>
</tr>
<tr>
<td>Over-Identification</td>
<td>2.13</td>
<td>3.32</td>
<td>+1.19*</td>
</tr>
<tr>
<td>SRAS-R-C</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Raw Score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>31</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escape</td>
<td>13</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention</td>
<td>21</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible</td>
<td>9</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring:

BYI-II:
T scores for the BAI, BDI, BANI, and BDBI are categorized according to their severity level as follows:
70+ = Extremely elevated, 60-69 = Moderately elevated, 55-59 = Mildly elevated, and <55 = Average (Beck, Beck, Jolly, & Steer, 2005).

T scores for the BDSCI-Y are categorized according to their severity level as follows:

>55 = Above average, 45-55 = Average, 40-44 = Lower than average, and <40 = Much lower than average. (Beck, Beck, Jolly, & Steer, 2005).

SCS:

Self-compassion mean score was calculated by adding mean scores for the self-kindness, common humanity, and mindfulness, and dividing by 3. Self-judgment mean score was calculated by adding mean scores for self-judgment, isolation, and over-identification, and diving by 3.

*Items reverse scored.

SRAS-R-C:

Scores for the SRAS-R-C were calculated using guidelines provided by Kearney (2008).
## Results of Pre-and-Post Measures – Participant 2

<table>
<thead>
<tr>
<th>Measures</th>
<th>Pre</th>
<th>Post</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>BYI-II (Raw Score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSCI</td>
<td>48</td>
<td>44</td>
<td>−4</td>
</tr>
<tr>
<td>BAI</td>
<td>29</td>
<td>27</td>
<td>−2</td>
</tr>
<tr>
<td>BDI</td>
<td>27</td>
<td>14</td>
<td>−13</td>
</tr>
<tr>
<td>BANI</td>
<td>28</td>
<td>25</td>
<td>−3</td>
</tr>
<tr>
<td>BDBI</td>
<td>10</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>(T-Score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>BDSCI</td>
<td>55</td>
<td>52</td>
<td>−3</td>
</tr>
<tr>
<td>BAI</td>
<td>61</td>
<td>59</td>
<td>−2</td>
</tr>
<tr>
<td>BDI</td>
<td>62</td>
<td>49</td>
<td>−13</td>
</tr>
<tr>
<td>BANI</td>
<td>60</td>
<td>57</td>
<td>−3</td>
</tr>
<tr>
<td>BDBI</td>
<td>51</td>
<td>51</td>
<td>0</td>
</tr>
<tr>
<td>SRAS-R-C (Raw Score)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Avoidance</td>
<td>18</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Escape</td>
<td>15</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Attention</td>
<td>27</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tangible</td>
<td>28</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Scoring:**

**BYI-II**

T scores for the BAI, BDI, BANI, and BDBI are categorized according to their severity level as follows:

70+= Extremely elevated, 60-69= Moderately elevated, 55-59= Mildly elevated, and <55= Average (Beck, Beck, Jolly, & Steer, 2005).

T scores for the BDSCI-Y are categorized according to their severity level as follows:

>55= Above average, 45-55= Average, 40-44= Lower than average, and <40= Much lower than average. (Beck, Beck, Jolly, & Steer, 2005).

**SRAS-R-C:**
Scores for the SRAS-R-C were calculated using guidelines provided by Kearney (2008).
Appendix I
Attendance Records – Participant 1 and 2

Attendance Records – Participant 1

<table>
<thead>
<tr>
<th>Month and Year</th>
<th>Number of Days Attended</th>
<th>Days of School</th>
<th>Percentage of Days Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 2017</td>
<td>0</td>
<td>18</td>
<td>0.00</td>
</tr>
<tr>
<td>Oct. 2017</td>
<td>2</td>
<td>20</td>
<td>10.00</td>
</tr>
<tr>
<td>Nov. 2017</td>
<td>9</td>
<td>21</td>
<td>42.86</td>
</tr>
<tr>
<td>Dec. 2017</td>
<td>1</td>
<td>11</td>
<td>9.09</td>
</tr>
<tr>
<td>Totals</td>
<td>12</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Mean Attendance</td>
<td></td>
<td></td>
<td>17.14</td>
</tr>
</tbody>
</table>

Scoring:

The percentage of school days attended was calculated by dividing the number of days attended by the days of school in each month, and multiplying by 100.
The mean percentage of attendance was calculated by dividing the total number of days attended by the total days of school, and multiplying by 100.

![Figure 8](image)

*Figure 8.* Graphical representation of the percentage of days Participant 1 attended from September to the middle of December 2017 including trend line.
**Attendance Records – Participant 2**

<table>
<thead>
<tr>
<th>Week</th>
<th>Number of Days Attended</th>
<th>Days of School</th>
<th>Percentage of Days Attended</th>
</tr>
</thead>
<tbody>
<tr>
<td>Sept. 2017</td>
<td>15</td>
<td>18</td>
<td>83.33</td>
</tr>
<tr>
<td>Oct. 2017</td>
<td>19</td>
<td>20</td>
<td>95.00</td>
</tr>
<tr>
<td>Nov. 2017</td>
<td>18</td>
<td>21</td>
<td>85.71</td>
</tr>
<tr>
<td>Dec. 2017</td>
<td>11</td>
<td>11</td>
<td>100.00</td>
</tr>
<tr>
<td>Totals</td>
<td>63</td>
<td>70</td>
<td></td>
</tr>
<tr>
<td>Mean Attendance</td>
<td>90.00</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Scoring:

The percentage of school days attended was calculated by dividing the number of days attended by the days of school in each month, and multiplying by 100.

The mean percentage of attendance was calculated by dividing the total number of days attended by the total days of school, and multiplying by 100.

*Figure 9. Graphical representation of the percentage of days Participant 2 attended from September to the middle of December 2017 including trend line.*

*Nonattendance during Week 13 was attributed to illness as reported by the principal.*