Background Information and Purpose of This Program

The treatment program presented in this guide is designed for youths with primary school refusal behavior. The treatment program is based on a functional model of school refusal behavior that classifies youths on the basis of what reinforces absenteeism. For children who refuse school to avoid school-based stimuli that provoke negative affectivity, we use child-based psychoeducation, somatic control exercises, gradual reintroduction (exposure) to the regular classroom setting, and self-reinforcement. This treatment package is designed to reduce unpleasant physiological symptoms, expose a child to various school-related items and situations, and gradually increase attendance.

For children who refuse school to escape aversive social and/or evaluative situations, we use child-based psychoeducation, somatic control exercises, cognitive restructuring, gradual reintroduction (exposure) to the regular classroom setting, and self-reinforcement. This treatment package is similar to the first functional condition but includes cognitive restructuring because many youths who escape aversive social and/or evaluative situations at school are older and more cognitively advanced. Social skills training with role-play may apply to this function as well. This treatment package is designed to reduce social and performance anxiety in key school-related situations, build or refine social/coping skills, and gradually increase attendance.

For youths who refuse school to pursue attention from significant others, parent-based treatment includes modifying parent commands, establishing regular daily routines, developing rewards for attendance and punishments for nonattendance, reducing excessive reassurance-seeking...
behavior, and engaging in forced school attendance under certain conditions. This treatment package relies on parent-based techniques to re-establish parental control via contingency management. Gradual return to school is emphasized as well.

For youths who refuse school to pursue tangible rewards outside of school, family-based treatment includes contingency contracts, communication skills training, escorting a child to school and from class to class, and peer refusal skills training. This treatment package relies on family-based techniques to increase incentives for school attendance, curtail social and other activities as a result of nonattendance, and improve problem-solving, negotiation, and communication skills. Supervision and gradual return to school are emphasized as well.

The first two treatment packages are primarily child-based. In contrast, the third treatment package is primarily parent-based and the fourth treatment package is primarily family-based. Although the specific treatment packages are quite different in their components, key goals of each are to reintroduce a child to the academic setting and achieve full-time school attendance with minimal distress.

**Problem Focus**

School refusal behavior refers to child-motivated refusal to attend school and/or difficulties remaining in classes for an entire day. Problematic absenteeism from school has been defined historically in many ways. For example, labels such as truancy (delinquent absenteeism), school phobia (fear-based absenteeism), and school refusal (anxiety-based absenteeism) are commonly used but do not represent all youths with trouble attending school. “School refusal behavior” is thus an overarching or umbrella construct that represents a child’s inability to maintain age-appropriate functioning vis-à-vis school attendance or adaptive coping to school-related stressors. Specifically, school refusal behavior refers to youths aged 5 to 17 years who:

- Are completely absent from school for periods of time
- Attend but then leave school during the day or skip certain classes
- Arrive late to school (chronic tardiness)
- Attend school following intense morning misbehaviors, such as temper tantrums or refusal to move, designed to induce absenteeism
- Display unusual distress during school days that leads to pleas for future nonattendance directed to parents or others

School refusal behavior is thus a dimensional construct that includes youths who miss long periods of school as well as those who rarely miss school but who attend under substantial duress. In addition, many youths with school refusal behavior show highly fluctuating attendance patterns. A youth may, for example, skip school entirely on Monday, arrive late to school on Tuesday, attend school Wednesday morning but not Wednesday afternoon, attend school Thursday, and attend school Friday under duress because of an important examination that day.

We have found that initial school refusal behavior often remits spontaneously, so substantial school refusal behavior is defined as cases lasting at least 2 weeks or a shorter time with significant interference in a family’s daily functioning. Acute school refusal behavior refers to cases lasting 2 weeks to 1 calendar year, having been a problem for a majority of that time. Chronic school refusal behavior refers to cases lasting more than 1 calendar year and, therefore, across at least two academic years.

Our definition of school refusal behavior excludes certain cases that may be outside the scope of this therapist guide. Primary exclusionary criteria include the presence of:

- Legitimate physical illness such as asthma that makes school attendance highly problematic
- School withdrawal, when a parent deliberately keeps a child home from school
- Familial or societal conditions that predominate a child’s life, such as homelessness or running away to avoid maltreatment
- Psychiatric conditions or other difficulties primary to school refusal behavior, such as academic failure, learning disorder, depression, bipolar disorder, hyperactivity, conduct disorder, psychosis, developmental disorder, substance abuse, and lack of motivation
- Profound family dysfunction such as extreme permissiveness and little parental supervision

- School-based verbal or physical threats or poor academic climate, including bullying, student–teacher conflict, inattention to a child’s curricular needs, or other legitimate concern

Up to 28% of American school-aged youths refuse school at some time, though the problem is considerably more prevalent in certain schools and geographical areas. In addition, many children show internalizing and externalizing disorders with school refusal behavior as a key element. School refusal behavior is generally seen equally in boys and girls and among families of various socioeconomic status. Most children with school refusal behavior are aged 10 to 13 years, but the problem also peaks at ages 5 to 6 and 14 to 15 years as children enter new schools. However, youths may show school refusal behavior at any age.

A hallmark of school refusal behavior is heterogeneity: dozens of presenting behaviors typify this population. Common internalizing problems include general and social anxiety, social withdrawal, depression, fear, fatigue, and somatic complaints (especially stomachaches, headaches, nausea, and tremors). Common externalizing problems include temper tantrums (including crying, screaming, flailing), verbal and physical aggression, reassurance-seeking, clinging, refusal to move, noncompliance, and running away from school or home. Many youths display a combination of internalizing and externalizing problems.

School refusal behavior has severe short- and long-term consequences if left untreated. Short-term consequences include significant child stress, declining academic status, social alienation, increased risk of legal trouble, family conflict, severe disruption in a family’s daily functioning, potential child maltreatment and lack of supervision, and financial expense. Long-term consequences include economic deprivation from a lessened chance of attending college, occupational and marital problems, substance abuse and criminal behavior, and poor psychosocial functioning, often involving anxiety and depression. Risk for these problems increases the longer a child is out of school. School refusal behavior is thus a common but vexing problem faced by educators and health and mental health professionals.
Development of This Treatment Program and Evidence Base

Alternative, traditional treatments for school refusal behavior are outlined in a later section. A key drawback of these approaches, however, is that they do not apply well to all cases of school refusal behavior. In contrast, our treatment program is designed to cover all cases of school refusal behavior by arranging commonly used therapeutic techniques tailored to a client’s individual characteristics.

Common therapeutic techniques in clinical child psychology and in this guide include essentials of systematic desensitization, cognitive restructuring, self-reinforcement, modeling and role-play, contingency management, contingency contracting, and communication skills training, among others. A full review of the well-demonstrated effectiveness of these techniques for youths with psychopathology is outside the scope of this guide (see Mash & Barkley, 2006). In addition, a review of the substantial general effectiveness of these techniques for youths with school refusal behavior and related conditions has been presented elsewhere (see Kearney, 2001, 2005).

The procedures in this guide have also been tested within the specific context of a functional, prescriptive model of school refusal behavior. Relevant research includes preliminary, uncontrolled work as well as a controlled study of prescriptive and nonprescriptive treatment (Chorpita, Albano, Heimberg, & Barlow, 1996; Kearney, 2002a; Kearney, Pursell, & Alvarez, 2001; Kearney & Silverman, 1990, 1999). The latter study indicated that a key measure in the functional model (School Refusal Assessment Scale-Revised) (see chapter 2) could accurately predict which prescriptive or tailored treatments would be effective for a particular case of school refusal behavior and which nonprescriptive treatments would be ineffective for a particular case of school refusal behavior.

Although the procedures in this guide have been shown to be highly useful for youths with psychopathology and school refusal behavior, the functional model remains in development. As such, we encourage clinicians to utilize our guidelines with appropriate caution. In addition, clinicians should consider recommending adjunctive treatments such as medication, family therapy, or educational interventions for learning disorders or classroom misbehavior as appropriate and necessary.
Cognitive-Behavior Therapy for Youths With School Refusal Behavior

The procedures in this guide are generally cognitive-behavioral in nature. The primary aims are to modify cognitions (where appropriate) and behaviors to enhance full-time school attendance without distress. Some procedures in this guide may be closely related to a family systems perspective as well. These include contingency contracting and communication skills training, but a behavioral, problem-solving emphasis is also laden upon these techniques. Clinicians who utilize the procedures in this guide will likely find them most familiar and useful if their training, experience, and background are derived from a cognitive-behavioral perspective.

Cognitive-Behavior Therapy Model of School Refusal Behavior

The primary cognitive-behavior therapy model presented in this guide is a functional one. Many behaviors characterize children who refuse school, which has led to poor consensus about conceptualizing, classifying, assessing, and treating this population. *We believe, therefore, that therapists should focus on the few maintaining variables in addition to the many forms of school refusal behavior.* Children generally refuse school for one or more of the following reasons, or *functions*:

- To avoid school-related objects and situations (stimuli) that provoke negative affectivity (symptoms of dread, anxiety, depression, and somatic complaints)
- To escape aversive social and/or evaluative situations at school
- To receive or pursue attention from significant others outside of school
- To obtain or pursue tangible rewards outside of school

*The first two functions refer to children who refuse school for negative reinforcement, or to get away from something unpleasant at school.* Common examples of school-related *objects* that children avoid are buses, fire alarms, gymnasiums, playgrounds, hallways, and classroom items. Common examples of school-related *social situations* that children avoid are inter-
actions with teachers, principals, and verbally or physically aggressive peers. Common examples of school-related evaluative situations that children avoid are tests, recitals, athletic performances, speaking or writing in front of others, or walking into class with others present.

*The latter two functions refer to children who refuse school for positive reinforcement, or to pursue someone or something attractive outside of school.* Many younger children refuse school to force parents to acquiesce to demands for physical closeness and extra attention. This function is sometimes linked to separation anxiety. In addition, older children and adolescents often refuse school for tangible rewards such as watching television at home, sleeping, playing sports, shopping, gambling, engaging in social parties with friends, and using substances. For these children, missing school is simply more fun than attending school. Therapists may be more apt to receive referrals for positively reinforced than negatively reinforced school refusal behavior. However, any type of school refusal behavior can be quite debilitating.

Some children, perhaps as many as a third, refuse school for two or more functions. For example, some children are initially upset about school activities and try to remain home to avoid them. These children may then realize the attractiveness of staying home and thus refuse school for negative and positive reinforcement. Conversely, some children miss school for long periods of time for positive reinforcement, but later must return to school and face new classes, teachers, and peers. This may provoke anxiety and lead to school refusal behavior for negative reinforcement as well.

Children who refuse school for multiple reasons generally require a more complex treatment strategy than children who refuse school for one reason. This strategy will likely involve a combination of treatment approaches and an extended timeframe. A combined-treatment strategy for these children is crucial as well because those who refuse school for multiple reasons have likely been out of school for a long period of time. This chronic situation tends to be resistant to a single treatment approach. Because children often refuse school for more than one reason, read the parts of this guide that apply most to your client as well as other parts that may be relevant.
Risks and Benefits of This Treatment Program

The treatment program described in this guide has the benefit of covering all youths with school refusal behavior, not simply those with anxiety-based conditions. Procedures arranged in this guide also represent well-tested techniques commonly used by clinical child psychologists. These techniques are carefully arranged by function to tailor treatment to the particular characteristics of a given child and follow a specific assessment process (see chapter 2).

An important caveat to this treatment program is that the procedures may not fully apply to youths with extreme symptomatology, comorbid diagnoses, marital or familial dysfunction, or physical illness or handicap. In cases of intense anxiety, depression, attention-deficit/hyperactivity disorder, or psychosis, for example, psychiatric consultation is particularly recommended. In addition, the treatment techniques may be less suited for youths whose primary behavior problem is not school refusal behavior or whose school refusal behavior is based on legitimate threat or complaint. Many of the procedures described here will be more useful if highly problematic comorbid situations are initially addressed and if parents and school officials are properly prepared to engage in extensive treatment. Pretreatment considerations are discussed in more depth in chapter 3.

Our procedures are generally delineated for prototypical cases of school refusal behavior. As a result, you may find some changes to be necessary for your particular case. Unforeseen circumstances always arise, and we have therefore tried to incorporate a sense of flexibility into these procedures. In similar fashion, you should be flexible when utilizing these procedures. For example, some cases of school refusal behavior take less time to resolve than what is described here, but other cases take more time. You should use this guide as just that—a guide—and be innovative when addressing this fascinating and often unpredictable population.

As the therapist, you can adjust the procedures in this therapist guide to your own style, a child’s cognitive-developmental status, relevant family issues that arise, and other pertinent factors. In general, however, this program is based on a cognitive-behavioral/family systems approach. If you are not familiar with this approach, then additional readings, train-
ing, and structured supervision may benefit you and your clients. This applies to all aspects of this guide, and especially to the cognitive re-structuring techniques in chapter 5.

Furthermore, do not “blend” this approach with others, such as adding a psychodynamic formulation or other theoretical orientation. This will serve to confuse children and parents and strays from the empirical basis for the program and its procedures. In addition, do not use these procedures in a group format. Although flexibility when using this guide is encouraged, increasingly greater deviation from its procedures may be correlated with diminishing benefits.

**Alternative Treatments**

Traditional treatments used by mental health professionals and educators for school refusal behavior have been single in nature and primarily include:

- Psychodynamic therapies to increase distance between a parent and child to reduce separation anxiety and/or improve a child’s self-esteem in the classroom
- Behavioral treatments based on systematic desensitization for children with a specific phobia of some school-related item
- Forced school attendance
- Family-based treatment techniques such as communication skills training and written/oral contracts among family members
- Antidepressant and anxiolytic medication
- Inpatient or residential programs to address youths with chronic school refusal behavior

*These single treatments work well for some, but not all, children with school refusal behavior.* For example, therapies designed to increase parent-child distance and improve child self-esteem may work best for young children with separation anxiety and an enmeshed family structure. However, these treatments are less effective for older children and adolescents without these problems. In addition, systematic desensitization
is effective for children fearful of a specific school-related item. However, this scenario applies only to a minority of those who refuse school. Forced school attendance may work well for young children or those who have just started refusing school, but it does not work well for older children or those with chronic attendance problems. Family-based techniques such as communication skills training and contracting require much verbal input from all family members. Therefore, young children may not be able to contribute. Medication works well for some but not all children, serious side effects may occur, and parents often do not prefer this treatment approach. Finally, inpatient or residential programs are variably effective, more directed toward chronic cases, and heavily dependent on level of parent support.

Because these different treatments work well only some of the time, a clear need exists to develop a thorough and comprehensive assessment and treatment approach for youths with school refusal behavior. This approach should address all youths with primary school refusal behavior, be easily implemented by therapists, and have effective therapeutic components. An overview of our prescriptive approach designed to meet these criteria is presented next.

**Prescriptive Assessment and Treatment Approach for School Refusal Behavior**

We have developed *a prescriptive approach* for assessing and treating all youths with primary school refusal behavior. We believe that four groups of youths with school refusal behavior can be based on the reasons (or maintaining variables or functions) why children refuse school. Again, these reasons include avoidance of school-related stimuli that provoke negative affectivity, escape from aversive social and/or evaluative situations, pursuit of attention, and pursuit of tangible rewards outside of school.

Descriptive and experimental functional analytical procedures discussed in chapter 2 may be used to conceptualize a particular child and assign him to one or more functional groups. *When a child's school refusal behavior has been assigned to one of these basic groups, then a specific treatment approach may be prescribed.* These treatment approaches differ depending on the group. If a child refuses school for more than one reason,
then a combination of treatments is prescribed. Overall, we believe that a prescriptive approach to treatment is the best strategy for addressing many different types of children with school refusal behavior. A brief overview of specific treatments per function was presented at the beginning of this chapter.

Specific Information for a Particular Case of School Refusal Behavior

Because school refusal behavior is often surrounded by many related problems, clinicians may be concerned about whether this therapist guide is indeed appropriate. In this section, we provide some questions you could raise during the screening process. The answers may give you a good idea as to whether our guide will be useful.

What If a Child Has Just Started Refusing to Attend School?

The answer to this question may be crucial for deciding whether to use this guide. If a child’s school refusal behavior has occurred sporadically for less than 2 weeks, then the problem is likely to end soon (self-corrective school refusal behavior). In this case, you may ask the family to call back in 1 week if the problem persists or schedule an appointment for 1 week later. In many instances, this appointment will turn out to be unnecessary because the child returned to school on his own.

The procedures in this guide might still be appropriate for brand-new cases, however, if school refusal behavior has been occurring every day for at least 1 week and is severe enough to create substantial family conflict or a serious disruption in a family’s daily functioning. In this case, and in cases where a child has refused school for more than 2 weeks, the procedures in this guide will be more applicable and useful.

What Is the Child’s Primary Behavior Problem?

A description of a child’s primary behavior problem is integral to the screening process and may help you decide if our procedures are warranted. Parents may struggle with this question, so ask whether compet-
ing behaviors are more severe than school refusal behavior. In essence, identify differential diagnoses or other problems that may explain a child’s presenting symptoms:

- For children refusing school to avoid school-based stimuli that provoke negative affectivity, common differential diagnoses or problems include panic disorder and agoraphobia, generalized anxiety disorder, specific phobia, and depression and suicidal behavior.

- For children refusing school to escape aversive social and/or evaluative situations, common differential diagnoses or problems include social anxiety disorder and depression and suicidal behavior.

- For children refusing school for attention, common differential diagnoses or problems include separation anxiety disorder, oppositional defiant disorder, or noncompliance in response to most parent commands.

- For children refusing school for tangible rewards, common differential diagnoses or problems include conduct-disordered behavior (e.g., stealing, fire-setting, aggression), substance abuse, and lack of motivation in many situations.

Note that any problem listed above could apply to any function of school refusal behavior. The disorders most commonly associated with each function are listed here. In addition, other problems could apply to any function, including attention-deficit/hyperactivity disorder, learning disorder or academic failure, and pervasive developmental disorders.

If these behaviors are primary to school refusal behavior, then our therapist guide may be only partially useful. We say “partially useful” because addressing school refusal behavior is sometimes the first step toward resolving other primary behaviors. This is so because missing school is often an urgent problem and one that parents want to initially address. For example, many parents of defiant children wish to start treatment by focusing on compliance to commands to attend school. In cases where the first step to an overall treatment plan is returning a child to school, the procedures described in this guide may be helpful.
Many parents are “in the dark” or confused and upset by their child’s problems, and are thus unable to provide detailed information about primary behaviors. In addition, a common parental mistake is to emphasize external (e.g., breaking curfew, not doing homework) and not internal (e.g., anxiety, depression) behavior problems. Scheduling a formal assessment session and asking more focused questions at that time may thus be appropriate. In the meantime, contact others (following consent) who can provide more insightful information. Examples include educational, medical, and other mental health professionals familiar with your case.

**What Other Factors Might Explain School Refusal Behavior?**

In many cases of school refusal behavior, other factors or variables instigate or explain the problem. The exclusionary criteria mentioned earlier may provide some guidelines for screening questions. For example, is a child’s school refusal behavior a direct result of medical problems such as asthma, pain, insomnia, diabetes, infection, or sensorimotor handicap? If this is possible, then refer the family for a medical examination. In addition, be sure to consult with a medical doctor as necessary and appropriate throughout treatment.

Another competing explanation for school refusal behavior is school withdrawal, where a parent deliberately keeps a child home from school. Because parents often wish to maintain the status quo in this situation, cases of school withdrawal are not often seen by therapists. However, one should be aware of likely scenarios just in case. Common reasons for school withdrawal include parental anxiety and need for a “safety” person, utilizing the child as a supplemental economic source (e.g., for work or babysitting), disguising child maltreatment, parental fears of a child being kidnapped at school by an estranged spouse, peer-related safety issues, and complaints about the quality or appropriateness of a teacher or school. In cases of school withdrawal, intervention with the parents and/or others is probably necessary and may not involve the procedures described here.
The presence of primary familial or systemic problems also diminishes the utility of this guide. For example, if a child is constantly running away from home and missing school to avoid sexual maltreatment, then resuming school attendance is not the immediate concern. In addition, many children miss school because their families have been ejected from their home. In these cases, a broader approach to treatment is clearly needed.

**What Is the Child’s Age?**

Knowing the child’s age is important for three reasons. First, some parents will refer to treatment children less than 5 years old for refusing to attend preschool or other activities. This problem is probably related to school refusal behavior in older children, but our guide is not meant to address preschoolers. If you use this guide for very young children, you will have to significantly adapt the discussed procedures and use them with substantial caution.

Second, a child’s age may be an important, but not always accurate, predictor of why he is refusing to attend school. In general, children aged 5 to 11 years tend to refuse school to avoid general negative affectivity and/or to receive attention. Conversely, adolescents aged 12 to 17 years tend to refuse school to escape aversive social or evaluative situations and/or to obtain tangible rewards outside of school. Although exceptions are common, and many children refuse school for multiple reasons, knowing a child’s age may help you devise an initial hypothesis about the function of school refusal behavior. Then, more specific questions can be asked in formal assessment (see chapter 2).

Third, knowing a child’s age may give you an early idea about treatment direction. For example, therapies that rely more on verbal content, such as cognitive therapy, may be more appropriate for adolescents than younger children. Conversely, forced school attendance is much easier to implement for a 6-year-old than a 16-year-old. Again, exceptions are common, but knowing a child’s age and cognitive level of functioning will help you formulate an efficient and effective treatment plan.
Is the Child’s School Refusal Behavior Extremely Severe?

Our guide may not apply to extremely severe cases of school refusal behavior. These cases most likely involve (1) extreme levels of negative affectivity such that any approach to school is almost impossible, (2) severe delinquent behavior, and/or (3) school absence longer than one calendar year. In these cases, alternative treatments may be necessary. In cases of extreme anxiety, for example, pharmacotherapy may be used initially to control physical anxiety symptoms and ease exposure to school. In cases of severe delinquent behavior, residential or inpatient treatment may help control explosive behaviors or establish some pattern of school attendance before outpatient therapy with family members. Alternative school programs may also be explored in cases of extended absence. These include part-time, night, credit by examination, independent study, home-bound, and vocational programs.

What If Your Model Does Not Fit My Case?

If our definition or prescriptive approach to school refusal behavior does not fit your case, then other procedures would, of course, be more appropriate. However, many procedures in this guide can be directed toward non-school refusal behaviors. For example, somatic control exercises, exposure-based practices, and cognitive restructuring procedures apply to those with general or social anxiety. In addition, contingency management and contracting procedures apply to family conflict or children with noncompliance. However, the procedures described in this guide are designed to specifically address children with primary school refusal behavior.

Youths on Medication

The procedures in this guide may still be used if youths are currently medicated for conditions directly related to school refusal behavior, such as anxiety or depression, or conditions perhaps unrelated to school refusal behavior, such as attention-deficit/hyperactivity or bipolar disorder. Ongoing consultation with the prescribing physician or psychiatrist
is strongly recommended during assessment and treatment. In many cases, treatment must be expanded to accommodate comorbid psychiatric conditions. However, the procedures in this guide can be woven into an expanded treatment protocol.

Outline of This Therapist Guide

This therapist guide is designed to provide you with an outline of our prescriptive approach for assessing and treating school refusal behavior in children. Not all procedures are discussed with as much depth as possible, of course, but the most crucial information is given to guide your clinical process. Chapter 2 describes our recommended assessment and treatment assignment procedures. Chapter 3 describes aspects of a consultation session, including suggestions for summarizing assessment results and making treatment recommendations to a family. Chapter 3 also contains important points to consider for each treatment phase.

Chapters 4 through 7 describe prescriptive treatment packages for each function of school refusal behavior. Sample dialogue, troubleshooting recommendations, and discussions of special circumstances are also included. Chapter 4 discusses prescriptive treatment procedures for children refusing school to avoid school-based stimuli that provoke negative affectivity. Chapter 5 discusses prescriptive treatment procedures for children refusing school to escape aversive social and/or evaluative situations. Chapter 6 discusses prescriptive treatment procedures for children refusing school for attention. Chapter 7 discusses prescriptive treatment procedures for children refusing school for tangible rewards. Finally, chapter 8 discusses issues related to slips and relapse prevention as well as recommendations for youths with chronic school refusal behavior.

Chapters 4 through 8 also contain a detailed discussion of special topics pertinent to treating youths with school refusal behavior. Although these topics have been linked to those functions in which they are likely most applicable, we recommend that you read each one. Chapter 4 includes special topics on medicating children with severe distress, home schooling, when to keep a child home from school, a child who will not ride the school bus, children who are distressed on Sunday evenings, and methods for gradually increasing school attendance time. Chapter 5 in-
cludes special topics on panic attacks, extracurricular activities, perfectionism, being teased, and attending gym class.

Chapter 6 includes special topics on parents skipping work to be home with a child, a child home from school during the day, and coming to school late in the morning. Chapter 7 includes special topics on 504 and individualized education plans, alternative school placements, calling the police, and problems getting out of bed. Chapter 8 also includes a discussion of special circumstances such as parents leaving for work before a child goes to school, multiple children in a family refusing school, children with developmental disorders, and children referred to the legal system for nonattendance. Other general suggestions in chapter 8, such as those for children starting a new school, are included as well.

Use of the Parent Workbook and Self-Directed Book

The clinical procedures in this guide are also described in a parent workbook. Parents who use the workbook are strongly urged to do so in conjunction with a qualified therapist. We recommend you give your clients a copy of the parent workbook. In doing so, they can be more prepared for the assessment and treatment process and ideally more motivated to complete therapeutic homework assignments. We also suggest, in case your clients have specific questions, that you become familiar with our descriptions of assessment and treatment procedures in the parent workbook.

A self-directed book designed for parents of youths with subclinical forms of school refusal behavior is also available (Kearney, 2007). Getting Your Child to Say “Yes” to School: A Guide for Parents of Youth with School Refusal Behavior outlines many of the procedures discussed in this guide and the parent workbook and may be especially useful as a reference for clients who complete treatment. The book is arranged by function and may be referred to by children and parents following treatment to help prevent relapse. A book designed for educators who address youths with school refusal behavior is also forthcoming. This book may be useful for clinicians who consult regularly with school personnel regarding cases of school refusal behavior.