Cognitive-Behavioral Treatment of Anxious Youth with Comorbid School Refusal: Clinical Presentation and Treatment Response

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Abstract

The present study investigated the effectiveness of cognitive-behavioral therapy in youth (N = 27) diagnosed with a principal anxiety disorder and school refusal (SR; denial to attend school or difficulty remaining in school). Scant research examines the effectiveness of cognitive-behavioral therapy for treatment-seeking youth with a primary anxiety disorder and comorbid SR. Effects for youth who completed treatment (N = 12) ranged from d = .61 to 2.27 based on youth- and parent-reported anxiety and depressive symptoms, as well as independently rated global functioning. A discussion of treatment drop-out, a case illustration, and treatment recommendations are provided.

Keywords: school refusal, youth anxiety disorders, cognitive-behavioral therapy

School refusal (SR) is characterized by the denial to attend school or difficulty remaining in school throughout the day (Kearney, 2007; Kearney & Bates, 2005). SR, as an overarching phrase, is used to describe a gamut of behavior exhibited by youth, which includes skipping parts of the school day, displaying extreme

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resistance to attending school in the morning, and constantly seeking the school nurse in order to be dismissed from school (Kearney, 2007). School refusal is a heterogeneous pattern of behavior that overlaps with externalizing disorders such as oppositional defiant disorder (ODD) and attention deficit hyperactivity disorder (ADHD), as well as internalizing disorders such as anxiety and depression (McShane, Walter, & Rey, 2001). Research indicates that SR behavior may be exhibited by 5-28% of youth and can lead to negative short-term and long-term sequelae (Kearney, 2001). Short-term difficulties include family conflict, delinquency, poor academic performance, and difficulties with peer relationships (Kearney, 2001; Last & Strauss, 1990; Naylor, Staskowski, Kenney, & King, 1994), whereas long-term sequelae include marital, occupational, and psychological problems (Flakierska-Praquin, Lindstrom, & Gillberg, 1997).

Kearney and Albano (2007) described youth with SR as those who refuse school to (a) avoid school-related objects or situations that cause distress or negative affect, (b) to escape aversive social and/or evaluative situations, (c) to receive attention from others outside of school, and/or (d) or to pursue reinforcement outside of school. Indeed, research studies indicate that SR is complex, with varying clinical presentations (King, & Bernstein, 2001). The complexity has led some to suggest that SR behavior be classified into different subtypes such as anxious school refusal (Berg et al., 1993; Last & Strauss, 1990), anxious/depressed school refusal (Berstein, 1991) and avoidant and malingering school refusal (Evans, 2000).

Researches on the diagnostic evaluations (i.e., disorders, severity) of children exhibiting SR due to anxiety have been reported (Bernstein, 1991; Last & Strauss, 1990). Last and Strauss (1990) investigated anxious school refusal in a referred clinic sample of 63 participants and reported that the most common primary diagnoses included separation anxiety disorder (SAD), social phobia (SP), simple phobia, and overanxious disorder (OAD; currently Generalized Anxiety Disorder; GAD). Bernstein (1991), investigating a clinic sample of SR children, found that those with comorbid anxiety and depressive symptoms showed more severe symptoms on anxiety and depression rating scales. Generally, patients with comorbidities of depressive and anxiety symptoms are said to have a more severe presentation, which in turn has implications for treatment (Dunner, 2001). The overlap between anxious and depressive symptoms in youth who refuse school is not surprising, considering the high comorbidity rates between anxiety and depression in childhood and adolescence (Axelson & Birmaher, 2001; Essau, 2003).

Given that anxious and depressive symptomatology seems to reflect an important component of SR behavior (Bernstein, 1991; Last & Strauss, 1990), cognitive-behavioral therapy (CBT) holds promise for remediation of SR. CBT is considered to be evidence-based in the treatment of both depressed (David-Ferdon & Kaslow, 2008) and anxious youth (Silverman, Pina, & Viswesvaran, 2008).

Indeed, the results of two randomized clinical trials (RCT) suggest that CBT may be an effective treatment in youth referred to a clinic for SR (King et al., 1998; Last, Hansen, & Franco, 1998). King et al. (1998) randomly assigned 34 youth to CBT or a waitlist condition. Relative to the waitlist controls, children who received CBT subsequently showed significantly higher rates of school attendance. Another study found similar results in 56 youth randomly assigned to CBT; although CBT was not evidenced to be more effective than an educational support condition (Last, Hansen, & Franco, 1998). These studies provide encouraging preliminary evidence supporting the use of CBT for the remediation of school refusal.

Despite the promising findings for CBT in cases where SR is the issue of primary concern, little research has examined the influence of comorbid SR amongst children with a principal anxiety disorder. As such, it is as yet unknown how SR affects the clinical presentation of youth with a principal anxiety disorder, or whether treatment outcome for anxiety disorders is affected when SR is present. One manual-based version of CBT for youth anxiety, the *Coping Cat Program* (Kendall & Hedtke, 2006a), is a 16 session program for youth (aged 8-13), with Generalized Anxiety Disorder (GAD), Separation Anxiety Disorder (SAD), and/or Social Phobia (SP). Treatment entails two segments: the first focuses on psychoeducation and building coping strategies, and the second emphasizes exposure to anxiety provoking situations (Beidas, Podell, & Kendall, 2008).

The present study (1) provides a clinical description of youth presenting to an outpatient anxiety disorders clinic with a principal diagnosis of GAD, SP and/or SAD and coexisting SR, and (2) evaluates the effectiveness of CBT for child anxiety in the treatment of these youth. We hypothesized that both anxious and depressive symptoms will significantly decrease over the provision of treatment and that youth will respond to CBT. Analyses included a description of initial symptom presentation as rated by self- and parent-report. Information regarding comorbidity is also provided. Following the results, an illustrative case example is described and discussed. Finally, specific clinical recommendations/adaptations found to be helpful in the treatment of this population are proffered.

METHOD

Participants

Participants (N = 27) were youth (7-16 years of age; *M* = 11.03, *SD* = 2.50) who presented for an assessment to receive treatment at the Child and Adolescent Anxiety Disorders Clinic (CAADC) of Temple University. Participants (17 males; 10 females) were Caucasian (N = 19), African American (N = 3), Asian (N = 1),

and Hispanic (N = 3)[1]. All children met criteria for a current classification of SR behavior; meaning that all children exhibited clinically meaningful school refusal behavior at a clinician severity rating of 4 or above (see Table 1).

Table 1. School refusal criteria

Rating	Description
1	Refusal to move, dawdling, clinging in the morning, but attending school.
2	School attendance under duress and pleas for nonattendance. Mornings difficult.
3	Repeated misbehaviors in the morning to avoid school. Morning routine is stressful. Visits to the nurse during school. Calling home. Less than 14 ($\pm$2) days of missing classes but more than 4 (per semester).
4	Repeated tardiness in the morning followed by attendance. Periodic absences or skipping of classes. Attending but then leaving school at some time during the day. At least 14 days this semester. Visits to nurse accumulating into missing more than 14 classes this semester.
5	Repeated absences, leaving early, or skipping of classes mixed with attendance. Missed 14 half or whole days of school this semester.
6	Complete absence from school during a certain period of the school year (more than 18 days).
7	Complete absences from school for an extended period of time (one month to 2 months).
8	Complete absence from school for a long period of time (more than 2 months).

Rating - Clinician severity rating

These children had primary current DSM diagnoses of GAD (N = 7; five males and two females), SAD (N = 9; six males and three females), and SP (N = 11; six males and five females)[2]. There was a significant difference in primary current DSM diagnosis (t $_{(26)}$ = 6.12; $p < .01$), such that more youth presented with a principal diagnosis of SP. See Table 2 for comorbidity information.

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[1] Child race was missing in the case of one youth.

[2] For six youth, school refusal behavior was determined to be the primary diagnosis based on parent and child report. However, given that school refusal behavior is not a DSM diagnosis, we were interested in characterizing the primary clinical DSM diagnosis assigned to these youth. For example, if a youth's primary diagnosis was school refusal, and secondary diagnosis was social phobia; they would be characterized as having a primary diagnosis of social phobia.

Table 2. Comorbid DSM-IV diagnoses for school-refusing anxious youth

Variable	Percentage	Variable	Percentage
Primary diagnosis of GAD	26	*Primary diagnosis of SP*	44
Comorbid diagnoses		Comorbid diagnoses	
School refusal	100	School refusal	100
SP	57	MDD	25
SAD	29	Dysthymia	25
Specific phobia	43	Selective mutism	8
OCD	1	Specific phobia	42
MDD	1	SAD	17
Dysthymia	1	GAD	42
ODD	1	Agoraphobia	8
ADHD-inattentive	1	PTSD	8
ADHD-combined	1	ADHD-attentive	8
		OCD	8
		ODD	8
Primary diagnosis of SAD	30		
Comorbid diagnoses			
School refusal	100		
GAD	50		
SP	25		
ADHD-inattentive	25		
Specific phobia	50		
PTSD	13		
ODD	13		

MASC = Multidimensional Anxiety Scale for Children
CDI = Children's Depression Inventory
CBCL = Child Behavior Checklist
$*p < .05; **p < .01$

Measures

The following measures were selected to ensure a multi-method, multi-informant assessment as encouraged in the literature (Eyberg, Schuhmann, & Rey, 1998; Kendall, Holmbeck, & Verduin, 2004).

Anxiety Disorders Interview Schedule-Child/Parent (ADIS-C/P; Silverman & Albano, 1996). The ADIS-C/P is a semi-structured parent and child diagnostic interview for collecting information about a child's symptoms and determining DSM-IV diagnoses. The ADIS includes a school refusal module which includes questions on school anxiety, situations/objects that cause anxiety at school, and severity and duration of absenteeism at school (Silverman & Albano, 1996). School refusal diagnoses were assigned in accordance with specified criterion (see Table

1). The ADIS-C/P demonstrates good psychometric properties (March & Albano, 1998) including high retest reliability (*kappa* from .78 to .88 for SAD, *kappa* from .71 to .92 for SP, *kappa* from .63 to .80 for GAD; Silverman, Saavedra, & Pina, 2001) and high interrater reliability (*kappa* = 1.00 for SP, *kappa* = .90 for GAD; Chavira, Stein, Bailey, & Stein, 2004).

Experienced diagnosticians who were advanced doctoral candidates in clinical psychology administered the ADIS-C/P. Trainees were required to reach an inter-rater reliability of .85 (Cohen's *kappa*), and the head diagnostic interviewer conducted ongoing diagnostic reliability checks by examining diagnostic interviews (diagnostic training detailed in full in Kendall et al., 1997).

Children's Global Assessment Scale (CGAS; Shaffer et al, 1983). The CGAS is a measure of a child's global psychological functioning during a specified time period. The CGAS consists of a 1-100 scale with behavioral descriptions and anchor points. The CGAS demonstrates high retest reliability (ICC from .69 to .95) and interrater reliability (ICC from .74 to .87), and is sensitive to level of impairment (e.g., discriminates between inpatients and outpatients, Bird, Canino, Rubio-Stipec, & Ribera, 1987; Dyrborg et al., 2000; Schorre & Vandvik, 2004; Shaffer et al., 1983).

Multidimensional Anxiety Scale for Children (MASC; March, Parker, Sullivan, Stallings, & Conners, 1997). The MASC is a 39-item self-report inventory composed of four major subscales rated on a 4-point Likert scale (from 0-never to 3-often): physical symptoms (e.g., tension), social anxiety (e.g., rejection), harm avoidance (e.g., perfectionism), and separation anxiety. The MASC has high retest reliability over 3 weeks or 3 months (intra-class correlations of .88 or .87 respectively, March et al., 1997; March & Sullivan, 1999) and has adequate convergent and discriminant validity (Dierker et al., 2001; March et al., 1997; March & Albano, 1998).

Children's Depression Inventory (CDI; Kovacs, 1981, 1992). The CDI is a 17-item measure of the cognitive, affective, and behavioral symptoms of depression rated on a 3-point Likert scale (from 0 to 2). The scale has demonstrated high internal consistency, moderate retest reliability, and is correlated with measures of related constructs (self-esteem, negative cognitive attributions, and hopelessness, Kazdin, French, Unis, Esveldt-Dawson, & Sherick, 1983; Kovacs, 1981). The CDI may be used to predict depressive disorders and discriminate depressive disorders from other disorders (Timbremont, Braet, & Dreessen, 2004).

Child Behavior Checklist (CBCL; Achenbach 1991). The CBCL is a 118 item parent-report measure of a child's functioning that assesses a broad range of children's behavioral problems and social competencies. Items are scored between 0 and 2 depending on the degree to which the particular statement characterizes the child. This checklist has been extensively studied and demonstrates strong psychometric properties: good internal consistency, test-retest reliability, cross-

informant agreement, stabilitiy of scale scores and good validity (Achenbach & Rescorla, 2001).

Design and Procedures

This study used an uncontrolled pre-post treatment design. Following informed consent, participants were administered the ADIS-C/P. Separate diagnosticians interviewed the parent(s) and child. Following the interviews, the diagnosticians individually assigned diagnoses which were combined into a composite diagnosis (integrating the independent diagnoses with the "or" rule, Silverman & Albano, 1996). Children were considered appropriate for treatment if their primary presenting problem was GAD, SAD, and/or SP. Other comorbidities were included as long as the primary problem was an anxiety disorder (e.g., Oppositional Defiant disorder, Attention Deficit/Hyperactivity Disorder, depression).

Children received either individual CBT (Kendall & Hedke, 2006b) or family CBT (Howard, Chu, Krain, Marrs-Garcia, & Kendall, 2000), both consisting of 16-20 sessions. Comparable youth outcomes are produced by the two treatments (Kendall, Hudson, Gosch, Flannery-Shoreder, & Suveg, 2008). The first half of treatment involved recognizing anxious feelings and somatic reactions to anxiety, clarifying cognition in anxiety-provoking situations, learning skills to help manage or ameliorate anxiety, evaluating one's abilities, and learning self-reinforcement. The second half of treatment involved practicing these techniques during anxiety-provoking situations (exposure tasks). The treatment was not developed to directly target school refusal; however, school related fears and anxieties were considered in treatment (e.g., included in the formation of the hierarchy of feared situations).

A number of youth who presented for assessment did not receive and/or complete treatment for a variety of reasons, leaving the total number of participants who received a full dosage of treatment and completed the post-assessment to be 12. ADIS, MASC, and CDI data are available for all treatment completers; CBCL data is available for a subset of participants. Reasons for not receiving treatment and/or treatment non-completion are outlined below. Post-assessment measures are missing for a number of youth (N = 15): (1) youth had the pre-assessment but dropped out before coming in for treatment (N = 5) for unknown reasons, (2) youth dropped out during treatment (N = 6), (3) youth completed treatment but did not complete a post-assessment (N = 3), (4) youth was referred out for treatment (N = 1) due to an inappropriate treatment match in the clinic.

RESULTS

Self-reported anxious and depressive symptoms. Significant improvement was reported across multiple domains relating to anxiety as rated by the MASC (See Table 3). Specifically, overall anxiety, physical symptoms, social anxiety, harm avoidance, and separation anxiety improved as reported by anxious youth. Effect sizes were in the moderate to large range (Cohen, 1988).

Table 3. Results for anxious youth with comorbid school refusal: before and after the treatment

Measure	N		Before treatment	After treatment	t-test	Effect size *d*
MARS T-scores						
MASC total score	13	M	59.31	37.15	2.84*	0.99
		SD	25.13	18.91		
MASC physical symptoms	13	M	14.85	9.23	2.45*	0.70
		SD	8.65	7.32		
MASC social anxiety	13	M	15.28	9.31	2.50*	0.83
		SD	8.18	6.28		
MASC separation anxiety	13	M	12.92	5.77	3.14**	0.99
		SD	8.25	4.36		
MASC harm avoidance	13	M	15.54	11.69	2.35*	0.64
		SD	6.33	5.75		
CDI						
CDI total score	12	M	11.75	5.67	2.68*	0.82
		SD	8.56	6.10		
CBCL T-scores (parent)						
Total problems T	8	M	66.22	54.00	3.47**	1.55
		SD	3.53	10.58		
Internalizing T	9	M	71.89	58.89	3.69**	1.52
		SD	4.37	11.27		
Externalizing T	9	M	54.56	49.44	1.77	0.60
		SD	7.26	9.61		
Global functioning score						
CGAS	9	M	50.22	73.33	5.16*	-2.27
		SD	6.24	12.92		

*p < .05; **p < .01

Depressive symptoms as reported by the youth decreased from pre- to post-assessment. Although participants' scores were not of the magnitude to warrant a diagnosis at baseline, considerable decreases in self-reported depressive symptoms were still displayed, with large effect sizes observed (Cohen, 1988).

Other reported symptoms. Pre- and post-treatment scores on the CBCL were available for a subset of participants who completed treatment (N = 9). Despite the smaller sample, significant differences were observed in both internalizing and total problem *T* scores. Importantly, the internalizing *T* score decreased from the clinical range (>70) to within the non-clinical range (<70).

Clinician-rated global functioning (rated during the pre- and post-treatment assessments by independent evaluators) indicated a considerable increase in global functioning with a large effect size (Cohen, 1988).

Drop-out. Of the 27 youth presenting for assessment, 13 (48%) completed the program. Chi-square analyses showed no significant differences in demographic measures (i.e., age, ethnicity, or gender) between those who completed treatment and those who did not. Independent samples *t*-tests demonstrated that there were no significant differences in pre-assessment self-report measures (i.e., MASC, CDI), parent-report measures (CBCL), or clinician-reported measures (i.e., CGAS). The one exception was the physical scale on the MASC (t_{24} = 2.03, p < .05, where completers (*M* = 16.83, *SD* = 8.71) had lower scores at pre-assessment when compared to non-completers (*M* = 24.29, *SD* = 9.84).

Treatment Outcome. Treatment responder status was evaluated in two ways. Type 1 responders were individuals whose principal diagnosis was no longer present at post-treatment as measured by the ADIS. For example, a child whose principal diagnosis at pre-treatment was SP would be characterized a type 1 responder if they no longer met criteria for a diagnosis of SP at post-treatment. Type 2 responders were participants whose principal diagnosis was no longer principal at post-treatment as measured by the ADIS. For example, a child whose principal diagnosis at pre-treatment was SP would meet criteria as a Type 2 responder if he/she completed treatment and met criteria for secondary SP at post-treatment. Outcome data, as measured by the ADIS-C/P was available for 12 participants. At post-treatment, 33% of youth (2 males, 2 females) continued to meet DSM-IV clinical criteria for primary SAD, 8% of youth (female = 1) continued to meet DSM-IV clinical criteria for primary GAD, and 0% of youth continued to meet DSM-IV clinical criteria for primary SP.

More than half of those who completed treatment, 58% (N = 7), were Type I responders, and 92% (N = 11) were Type II responders. With specific reference to SR, 75% (N = 9) of treated participants with school refusal at pretreatment did not meet criteria for school refusal at post-treatment (i.e., SR was not present in the diagnostic profile after treatment).

DISCUSSION

The present results indicate that anxiety-disordered youth who present to an anxiety clinic with school refusal show significant reduction in anxiety and in school refusal from pre- to post-treatment following a 16 to 20-session course of CBT. Improvement was seen both on parent- and self- rated measures of anxiety. Following treatment, improvement was also seen on a clinician-rated global functioning. Regarding anxiety outcomes, the responder rates to CBT are not surprising; other randomized controlled trials have found CBT to be effective with youth who refuse school (King et al., 1998; Last, Hansen, & Franco, 1998). However, the findings with SR youth are encouraging given that the present treatment *did not exclusively* target SR behavior but focused more globally on the anxiety that was the antecedent of the SR behavior.

An interesting finding emerged from the differential rates of primary DSM diagnoses with comorbid SR behavior. The data indicate that higher numbers of youth presenting for treatment had a principal SP (social phobia) diagnosis. This finding is important given other data that youth with a principal SP diagnosis have more severe symptoms at pre-treatment, higher levels of depressive symptoms, and tend to have a slightly less favorable response to CBT (Crawley, Beidas, Benjamin, Martin, & Kendall, 2008).

It is important to note that children with SR showed very high drop-out from treatment (41%). Keep in mind that children who dropped out of treatment did not significantly differ from treatment completers on pretreatment self-report measures of anxiety or depression, parent-reported measures of child behavior or on clinician-reported measures of severity. However, children who dropped out of treatment did endorse more physical symptoms of anxiety-perhaps indicating intense physiological arousal making it difficult to attend school. What may have caused these high rates of dropout is unknown but possible explanations include (1) the treatment did not directly target SR, or (2) the more severe physical symptoms of anxiety detract from completing/attending treatment. Consistent with the first notion, children who dropped out may have had more ingrained patterns of school refusal and/or were in need of treatment that is more intensive. Additionally, the Coping Cat traditionally begins with 8 weeks of psychoeducation followed by exposure tasks in the second 8 weeks. This model may be less effective for youth with school refusal behavior (i.e., school exposures need to start right away)[3]. The second hypothesis is consistent with research demonstrating that somatic symptoms were associated with decreased school attendance in youth with SR and comorbid anxiety or depressive disorders (Bernstein et al., 1997). It is also reasonable to suggest that the very same issues contributing to school refusal contribute to refusal to complete treatment.

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[3] For youth presenting with primary school refusal behavior, we refer the reader to Kearney and Albano's treatment procedures described in their therapist manual.

The present study has limitations. For example, the study did not measure antecedents of school refusal (e.g., anxiety, oppositionality, dysphoria; Kearney & Albano, 2006). However, rates of externalizing disorders were not in the clinical range in this sample, so it is unlikely that externalizing problems were significantly contributing to SR in this sample. Future work might include larger samples that could be divided into groups based on their type of school refusing behavior. Another limitation is the absence of a control group: it is possible that youth not receiving CBT for anxiety could demonstrate improvement in SR. Finally, although this study used specific guidelines to assess the severity of school refusal, there is yet no universally accepted measure/definition of school refusal severity. Researchers have used varying methods to assess school refusal (Kearney & Albano, 2006), suggesting that consistency in measurement would improve research in this field.

Despite some limitations, the present results indicate that CBT, specifically the Coping Cat, is effective at reducing anxiety and school refusal in children with principal SP, SAD, or GAD and comorbid SR when youth are able to complete treatment. Additional research will help identify the optimal treatment, particularly given the need to address elevated treatment drop-out. Treatment recommendations based on our experiences in treating youth with primary AD and comorbid SR are provided following this case illustration.

Case Example

Grace, the case illustration, received a manualized treatment (i.e., the *Coping cat program,* Kendall & Hedtke, 2006a*)*, applied flexibly but with fidelity (Kendall & Beidas, 2007) to address comorbid school refusal and her principal anxiety disorders.

Case: Grace

Grace, a 16-year-old Caucasian female, presented for an assessment following a week of being unable to attend school due to severe anxiety and extreme somatic complaints. The new school year had just begun, and Grace was refusing school after attending school daily for just one week in September. Grace did not exhibit a history of past school refusal behavior. Following a structured diagnostic interview, Grace met criteria for a principal diagnosis of SP along with comorbid school refusal, SAD, and several specific phobias. A functional assessment of her school refusal suggested that it was primarily avoidant in nature. In other words, Grace displayed school refusal behavior in order to avoid her anxious somatic feelings and thoughts.

In her first treatment session, Grace was tearful and reported being distressed that she was unable to attend school. Grace had good social support at school and

was an excellent student, at the top of her class. Grace identified a number of anxious thoughts while at school grounds; including being afraid that she would do something embarrassing or that something terrible was going to happen. These thoughts seemed to be linked to intense physiological arousal, which in turn caused gastrointestinal distress accompanied by heart palpitations. She reported that certain non-academic classes (e.g., art) would bring on these debilitating thoughts and somatic symptoms. Grace's distress had become so interfering that she was no longer able to attend school.

Usually, the *Coping Cat program* (Kendall & Hedtke, 2006a) follows a particular weekly sequence. However, given Grace's high level of distress and the pressing importance of a return to school, she and her therapist met twice weekly for the psychoeducation portion (first half) of treatment. A behavioral plan was crafted from the very beginning of treatment. Grace agreed to try going to school for one class period the following day after her first session. To provide Grace with a coping strategy to use under anxious arousal, the therapist introduced her to relaxation. Grace downloaded her relaxation exercise to a digital media device, which she could keep with her and listened to as necessary. Additionally, Grace and her therapist selected a rewarding activity that Grace could engage in after attending one class period at school. The therapist worked closely with the school guidance counselor and school staffs to ensure the accommodations necessary for Grace to return to school in a gradual process were implemented.

Although attending class aroused intense anxiety in Grace, she was able to successfully get to school via telephone coaching with her therapist, and then stay through one class period. As part of treatment, one class period of attendance was added each day thereafter. At the end of two weeks, Grace was able to attend school daily, although she reported continuing to experience high levels of distress in particular classrooms. Nevertheless, she had come to learn and understand the cycle of avoidance, and was willing to make the effort to stay in the fearful situations in order to decrease her anxiety. She continued to meet with her therapist twice weekly until education about anxiety, relaxation, and cognitive restructuring portions of treatment (first half) were completed. Although Grace was able to attend school daily, it took several months for her anxiety levels to subside, and there were frequent presentations and/or school performances that would result in a spike in her anxiety ratings.

During the portion of treatment that involves exposure tasks, the therapist and Grace came up with a hierarchy of feared situations, many of which included school related situations (e.g., giving a presentation, performing in the school play).Treatment also addressed non-school related anxiety-provoking situations which caused Grace distress (e.g., going to the movies, sleepovers, applying to college). In the end, Grace responded very well to treatment and experienced great mastery over many of her feared situations.

Grace came to treatment with several strengths: She was very intelligent and was able to understand the consequences of avoidance. Both likely contributed to her willingness to subject herself (both with her therapist and on her own) to the exposure tasks that, initially, evoked high levels of anxiety.

Treatment Recommendations

Based on our work with anxious youth with comorbid SR, we suggest:

- Given the severity of the interference associated with SR behavior, it is essential for treatment to begin immediately with little delay between initial office contact and treatment commencement.
- Taking time to build rapport via longer and more frequent early sessions is recommended, to increase collaboration and decrease attrition.
- A thorough functional assessment of SR behavior will guide treatment. If SR is related to specific fears, these fears need to be addressed.
- The therapist should collaborate with the parents to make sure that the child's home environment is not reinforcing the school refusal. Preferably, the child's home routine should be as similar as possible to their school day routine, and should not include pleasurable or preferred activities (e.g., television, computer games, sleeping late).
- Involve the school early and often. Schools provide valuable information about the child and are needed in the process of reintroducing a child to the school environment.
- Reintroduction to school can be a gradual process. For example, a child may only be willing to sit in the school parking lot for the first exposure. He or she may later only be able to sit in the school nurse's office for half a day. Steady and progressive exposure to the feared context the child is needed.
- CBT for anxiety with comorbid SR should begin reintroduction to school as early as possible. Basic psychoeducation and skills building may be built into treatment in an abbreviated manner early in treatment.
- Rewards for achieving goals of reintroduction to school need to be built into the reintroduction. For younger children this may be in the form of small daily rewards, whereas older children may receive points that may be used towards a prize later in treatment.

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