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School Personnel's Knowledge and Perception of School Refusal Behavior

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SCHOOL PERSONNEL'S KNOWLEDGE AND PERCEPTION OF SCHOOL REFUSAL BEHAVIOR

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Dissertation Approval

This is to certify that the thesis presented to us by _____ on the _____ day of _____, 20___, in partial fulfillment of the requirements for the degree of Doctor of Psychology, has been examined and is acceptable in both scholarship and literary quality.

Committee Members' Signatures:

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Abstract

This study examined the knowledge of school personnel regarding risk and protective factors, the four-function model, assessment, and treatment of school refusal behavior. This study also explored the perceptions of school personnel regarding the understanding of school refusal behavior as an emotional condition versus its being delinquent behavior and the climate of understanding at their work setting. Two hundred, ninety-six mental health and non-mental professionals who currently work in school settings across the United States participated in this study by completing an online survey pertaining to this topic. Results indicate that mental health professionals demonstrated a higher level of knowledge than non-mental health professionals regarding risk factors and protective factors. School personnel from both groups demonstrated limited knowledge of the four-function model of school refusal behavior. School personnel from both groups perceived differences, emotionally and behaviorally, between students who demonstrated emotionally-based school refusal behavior and delinquent behaviors. There were inconsistent results regarding school climate as school personnel indicated that students from either group were treated the same, although school personnel from the both groups indicated that staff were supportive of students by helping determine their reasoning for being absent and understanding financial difficulties and a lack of resources they may be facing. Mental health professionals demonstrated adequate knowledge of assessment and treatment modality of school refusal behavior and limited knowledge of effective counseling strategies. Based on this information, school personnel should receive additional training and professional development, especially in the areas of the four-function model and treatment of school refusal behavior.

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CHAPTER 1

INTRODUCTION

Education is the key to success, providing children and adolescents with knowledge and experiences necessary to become the future leaders in various industries. School is supposed to be a safe and nurturing environment for students to flourish academically, adaptively, and socially. However, some students attempt to avoid or refuse to attend school and are considered to be demonstrating school refusal behavior. School refusal behavior, according to Kearney and Silverman (1996), refers to the refusal to attend school and/or difficulty remaining in classes for an entire day. About 5 to 28% of children and adolescents demonstrate school refusal behavior nationwide (Kearney, 2003). There are several risk factors and protective factors that are linked to school refusal behavior including child and adolescent variables, family variables, community variables, and school climate and peer variables (Wimmer, 2011). Furthermore, school refusal behavior, as with so many other behavioral conditions, is considered to be on a spectrum. Children and adolescents who exhibit school refusal behavior may miss long periods or sporadic periods of school time, skip classes, or arrive tardy to school; they may display severe morning misbehaviors in attempt to refuse school, or attend school with great dread and somatic complaints that precipitate pleas for future nonattendance (Kearney, 2003). The conceptualization of school refusal behavior has changed greatly since it was first identified. In previous years, researchers attributed school refusal behavior to parental attachment (Broadwin, 1932). Currently, school refusal behavior is looked at through a four-function model (Kearney & Silverman, 1990).

The four functions in the model developed by Kearney and Silverman (1990) include attention, escape, tangible, and avoidance. By conceptualizing school refusal behavior in this manner, the model assists in delineating the differences in function or in reason why students refuse to attend school, including differentiating between behavior related to mental health and that which is better defined as truancy. Truancy is a term used to describe any unexcused absence from school. However, Wimmer (2013) indicated that, historically, the term truant has been used to describe students who lack emotional reasons for their absences from school, such as anxiety, and they may also be involved in illegal activities. For school personnel with limited knowledge and background in mental health, school refusal behavior, as a manifestation of anxiety, can often be confused with students who are truant. Consequently, students are treated or disciplined in the same manner, as if both are truant.

Given the lack of consensus among professionals regarding school refusal behavior, the perceptions and discipline of students who demonstrate school refusal behavior, within any function, are often the same. Often school staff perceive children and adolescents as exhibiting the fourth function of school refusal behavior, tangible reinforcement. With the function of tangible reinforcement, there is a lack of anxiety-based symptomology related to this function. Instead, students refuse school to obtain tangible reinforcement outside of school, such as riding bikes, engaging in activities with friends, staying home to sleep or watch television, or engaging in drug use or delinquent activities (Kearney, Lemos, and Silverman, 2004). Students who demonstrate the tangible reinforcement function often have extensive family conflict or problematic family dynamics (Kearney and Silverman, 1995). Whether a student is labeled as exhibiting

school refusal behavior or truancy depends much upon the way the problem was initially perceived, on the later behavior, and on the way the child was dealt with by the school and school-related agencies (Cooper and Mellors, 1990). Cooper and Mellor conducted a study of teachers' perceptions of students who exhibit school refusal behavior and students who demonstrate truancy. The researchers distinguished the two by indicating that students who exhibited school refusal were emotionally disturbed, showing higher levels of anxiety, depression, and stubbornness than those with truancy. The study found that teachers were able to distinguish clearly those students who exhibited school refusal behavior and those students who were truant. There were limitations to this study, however. The study included a small sample size of 26 educators; they were teaching in a special unit that was specifically designed for student who were traditionally considered to demonstrate school refusal and truancy behaviors. Therefore, the educators may have had more experience and a better understanding of the differences in behavioral patterns among the two groups.

One of the major concerns as outlined by Cooper and Mellors (1990) was with labeling students. Once they are labeled as truant, disruptive, or exhibiting school refusal behavior, it can be very difficult for the student to lose or change the label. Furthermore, the label given determines a subsequent intervention plan. If a student is misidentified, it could affect the treatment he or she receives and, also, possible outcomes. Maynard and colleagues (2015) found that cognitive behavior therapy has proven to be the most effective treatment method for children and adolescents who demonstrate school refusal behavior as a manifestation of anxiety. Additionally, Heyne and colleagues (2001) found that pharmacological treatments were also effective in treating anxiety-based school

refusal behavior. The pharmacological agents are used to treat the symptoms of anxiety directly. Heyne and colleagues also found that cognitive behavioral therapy should be the first line of defense in the treatment of anxiety-based school refusal behavior; however, pharmacological treatment should be introduced simultaneously or subsequently.

Individuals who interact with and/or service children and adolescents who demonstrate school refusal behavior are spread throughout psychology, education, social work, medicine, sociology, criminal justice, and other disciplines (Kearney, 2003). Kearney reported that there has been little attempt to merge these different views regarding school refusal, which has led to general stagnation regarding the issue and this, consequently, further drives the problem. In addition, Kearney suggested that to build a consensus among the various disciplines, more collaboration is necessary. This collaboration may involve developing interest groups to gather professionals who address the population, developing conferences and workshops where the interest groups can meet, developing informational websites, increasing connections to the various national associations, and collaborating on grant proposals for multiple site studies. Kearney concluded that until there is greater dialogue among those who most often deal with school refusal behavior, the understanding of school refusal behavior will continue to risk being in disarray.

This study proposed to gain a better understanding of the knowledge and perceptions that school personnel hold regarding school refusal behavior. For the purposes of this study, school personnel included school administrators, school counselors, school psychologists, school social workers, pupil personnel workers, teachers, and school nurses. These personnel were classified as mental health

professionals and non-mental health professions. Mental health professionals included school psychologists, school counselors, pupil personnel workers, and school social nurses. The differences in the two groups were identified by their professions and the training they receive within these professions. Mental health professionals are trained in mental health and mental disorders; whereas, non-mental health professionals do not obtain in-depth training in these areas. This study proposed to gain an understanding of the disparity in the level of knowledge between school-based mental health professionals and non-mental health professionals regarding school refusal behavior. The level of knowledge was broken down into different factors including the four-function model, risk and protective factors, assessment and treatment of school refusal behavior. Furthermore, the study proposed to identify the perception that each profession holds regarding school refusal as part of an anxiety disorder versus truancy. Last, the study proposed to identify the level of need for additional professional development for each profession regarding school refusal behavior and the type of professional development that is needed. Specifically, the study addressed the following research questions:

1. What is the difference in the level of knowledge of school refusal behavior among school personnel?
    a. H_1= Mental health professionals demonstrate a higher level of knowledge than non-mental health professionals regarding school refusal behavior as it relates to risk and protective factors.
    b. H_1= Mental health professionals demonstrate a higher level of knowledge than non-mental health professionals regarding school refusal behavior as it relates to the four-function model.

2. What is the difference in the perception of school refusal behavior among school personnel?
    a. H_1: Mental health professionals perceive school refusal behavior as an emotionally-based condition (avoidance, escape, and attention) as opposed to delinquent behavior (tangible reinforcement).
    b. H_1: Non-mental health professionals perceive school refusal behavior as delinquent behavior (tangible reinforcement), as opposed to an emotionally-based condition (avoidance, escape, and attention).
    c. H_1: Mental health professionals and non-mental health professionals perceive the climate of their schools, as it relates to the understanding and discipline of school refusal behavior, negatively.
3. What is the level of knowledge among mental health professionals regarding the assessment and treatment of school refusal behavior?

CHAPTER 2

LITERATURE REVIEW

School refusal behavior refers to refusal to attend school and/or difficulties remaining in classes for an entire day (Kearney & Silverman, 1996). However, there are many terms that are used when describing school refusal behavior, such as school phobia, truancy, absenteeism, chronic non-attendance, emotionally-based school refusal, and school refusal behavior. According to Kearney (2003), school refusal behavior is often described as being on a spectrum. The spectrum includes children and adolescents who miss long periods or sporadic periods of school time, skip classes, or arrive tardy to school, display severe morning misbehaviors in attempt to refuse school, or attend school with great dread and somatic complaints that precipitate pleas for future nonattendance.

Approximately 5 to 28 percent of children and adolescents at one time or another display school refusal behavior (Kearney, 2003). According to Kearney and Bates (2005), gender, race, and socioeconomic status of students who demonstrate school refusal behavior were represented fairly equally. Kearney (2001) identified a few factors regarding school refusal behavior; namely, it was seen more commonly among young adolescents and students entering new school buildings for the first time. This included the transition to kindergarten; from elementary school to middle school, or middle school to high school, and when beginning in a new school after a recent move. Students who exhibited school refusal behavior showed a wide variety of externalizing and internalizing problem behaviors. These problem behaviors included depression, anxiety, fear, fatigue, somatic complaints, noncompliance, aggression, clinging, temper tantrums, refusal to move, and/or running away from school or home (Kearney, 2001). Given the

range of problem behaviors, it may be evident that students who exhibit school refusal behavior may have comorbid emotional and behavioral disorders. Some examples included social anxiety disorder, separation anxiety disorder, generalized anxiety disorder, panic disorder, selective mutism, oppositional defiant disorder, and depression (Kearney & Albano, 2004). From these definitions and descriptions, it is clear that school refusal behavior may stem from an emotional condition such as anxiety or depression or it is just another form of truancy.

Early Conceptualization of School Refusal Behavior

The first individual to delineate school refusal behavior from truancy was Isra Broadwin, a medical doctor from New York City. Broadwin (1932) found that children with emotionally-based school refusal often missed varying amounts of school, consistently, and with parental knowledge. He further stated that the child feared going to school, but was content at home. Additionally, there was no history of previous behavioral issues. Conversely, he described truancy as defiance. The delineation between school refusal behavior and truancy was later distinguished even further. In the 1930s to 1940s school refusal behavior focused on attachment and family issues such as parental knowledge of the absence (truancy), anxiety-based (school refusal), family enmeshment (separation anxiety), fear of school-related stimuli (school phobia), and other variables (Kearney, 2007; Johnson et. al., 1941; Sperling, 1967). Later, Bernstein and Garfinkel (1986) proposed that children and adolescents who demonstrated school refusal behavior could be divided into those with a mood disorder, anxiety disorder, both disorders, and those with neither disorder. Unfortunately, the studies included a restricted range of youth with only anxiety-based school refusal behavior. Furthermore, other researchers have

found considerable heterogeneity of diagnoses among this population, including a substantial number of participants who did not meet criteria for any mental disorder (Kearney, 2007). The heterogeneity in the characteristics of students who demonstrated school refusal behavior has made it difficult to classify them into specific categories based on diagnostic or familial traits.

Recent Conceptualization of School Refusal Behavior

More recently, behaviorists have focused on conceptualizing school refusal behavior by functions (Kearney, 2001). This involved maintaining factors such as learned responses to reduce anxiety or to pursue more enticing rewards outside of school. Many studies have concluded that classifying youth with school refusal behavior based on behavior forms (anxiety, depression, etc.) was highly problematic due to not being able classify students neatly into categories such as school refusal or truancy. Instead, greater overlap occurs among these categories (Kearney, 2007). A number of research articles have proposed an alternative method that has been designed to help resolve these issues. This alternative solution involved a functional approach that organized these youth with school refusal behavior, based on the primary factors that maintain the behavior.

Functions of school refusal behavior. Currently, school refusal behavior is divided into a four-function classification system. The four functions are intended to delineate various aspect of the problem, such as externalizing versus internalizing problem behavior, negative reinforcement versus positive reinforcement, and the particular cause of the behavior. Later discussion will address how children and adolescents are assessed and classified in each category. Overall, the four functions suggested by Kearney and colleagues to categorize school refusal behavior included

avoiding school-based stimuli that provoke negative affectivity (avoidance), escaping aversive social and/or evaluative situations (escape), pursuing attention from significant others (attention), and pursuing tangible reinforcers outside of school (tangible reinforcement) (Kearney, 2003; Kearney & Albano, 2004; Kearney & Silverman, 1996). The first two functions are maintained by negative reinforcement, but the third and fourth functions are maintained by positive reinforcement. The functional model of school refusal behavior has several potential advantages over previous systems that are based on behavior forms according to Kearney (2007). The model encompasses all youth with school refusal behavior, not just anxiety-based school refusal. Additionally, the model has been linked to specific assessment and treatment strategies (Kearney & Albano, 2000). Furthermore, Haight and colleagues (2011) conducted a confirmatory factor analysis of the primary measure for this model, the School Refusal Assessment Scaled-Revised, which supports the discriminant validity of the four-function model.

Avoidance. The first function identified by Kearney and colleagues involves the avoidance of school. According Wimmer (2011), as part of the avoidance function, youth refused to attend school to avoid situations or stimuli that result in negative affectivity. Children and adolescents who were avoidant stayed home as a result of feelings of dread, anxiety, depression, and somatic complaints. Kearney and colleagues (2004) posited the theory that children and adolescents who were avoidant sometimes identified specific triggers to their school refusal behavior, such as peer-based threats; they indicated more often, however, that they feel bad while they are in school and desire homeschooling. Other stimuli that generated negative affectivity were transitions in which the child must engage, including the car/bus to class, the class to the cafeteria, or the playground to

music class. Students who are considered avoidant tend to be sporadic in their attendance in school and implore parents to remove them from school entirely. The behavior is reinforced when they are able to avoid aversive feelings and thoughts. Kearney and Albano (2007) indicated that youth within the first function of school refusal included youth depression and suicidal behavior, and youth who were historically called school phobic, youth who demonstrated separation anxiety, panic disorders, specific phobias, and generalized anxiety disorder.

Escape. The second function proposed by Kearney and colleagues involves the escape function. Wimmer (2011) indicated that children and adolescents refused to go to school in order to escape aversive social or evaluative situations. The children and adolescents who demonstrate the escape function are generally characterized as socially anxious. Kearney and colleagues (2004) found that students who demonstrated the escape function were often older children and adolescents. Common problematic social situations for children and adolescents who were attempting to escape involved starting and maintaining conversations with peers, cooperating or playing games with others, participating in other group activities, and eating in the cafeteria with others. Typical problematic evaluative situations included tests, oral presentations, writing on the blackboard, walking in the hallways or into a classroom, and participating athletically or musically in front of the class. Lyon and Colter (2007) found that youth who identified with this subtype most often included urban, low-income, ethnic minorities who had given up, who lacked family that valued education, and students who were frequently exposed to negative experiences in school. This allowed students to avoid humiliation or to protect their self-esteem. Kearney and colleagues (2004) found that students tended to

refuse school only during key evaluative situations, although others displayed more extensive absenteeism. In many cases, children and adolescents were found to refuse school for a combination of the first and second functional conditions (Kearney et al., 2004).

Attention. The third function posited by Kearney and colleagues involves gaining attention for not going to school. Most students that fall within this function are younger children (Kearney, et al., 2004). Children and adolescents who are identified within this function avoided school to gain attention from family members or others in their environment, demonstrated characteristics of exaggerated levels of separation anxiety to gain attention, and may have been manipulative and defiant and engaged in acting-out behaviors such as tantrums (Wimmer, 2011). Although separation anxiety is common with children and youth under this function, the main characteristic was attention-seeking behavior (Kearney, et. al., 2004).

Tangible reinforcement. The fourth function theorized by Kearney and colleagues involves acquiring some form of tangible reinforcement. Individuals who fall within this function generally refuse to go to school so they can, instead, obtain tangible reinforcements outside of school. Children and adolescents whose school refusal is maintained by tangible reinforcement are often more interested in watching television, sleeping, partying with friends, or using drugs and/or alcohol. Although this function does not include an emotional component, the child or adolescent may develop negative affectivity or a discomfort with school after a long period of absence (Wimmer, 2011). Kearney and Albano (2007) found that students who demonstrated school refusal as a function of tangible reinforcement generally tended to be older and demonstrated higher

rates of behaviors associated with conduct disorder, such as stealing or aggression. Furthermore, Kearney and colleagues (2004) found the absenteeism of the children and adolescents within this function tended to be more chronic and was often associated with extensive family conflict. Generally, students who fall under this function are more typically identified as truant students.

Truancy Behavior

Truancy is another term under the umbrella of school refusal behavior. However, it represents a different population of children who demonstrate school refusal behavior. Truancy is associated with state compulsory attendance laws. Truancy is a term used to describe any unexcused absence from school. Wimmer (2013) indicated that historically, the term truant was used to describe students who were absent from school, lacked an emotional reason for their absences, such as anxiety, and may have been involved in illegal activities. Therefore, truancy is considered synonymous with the fourth function of the four-function model of school refusal, tangible reinforcement. Truancy is often described in ways similar to school refusal behavior, but included the attribution of "antisocial characteristics" (Berg, Nichols, & Pritchard, 1969) or a lack of parental knowledge about the absence (Berg et al., 1993; McShane et al., 2001). Generally, each state has its own prescribed way to describe truancy within the school setting. Although truancy is considered any unexcused absence from school, the term truant often applies to students who are chronically absent and may end up referred to truancy court. Wimmer (2013) indicated that some students who miss school for emotional reasons were referred for truancy actions if the state standard for the number of unexcused absences was met. Although truancy may not be seen as an emotionally-based problem, it is still considered

a problem and it should be addressed. Enea & Dafinoiu (2009) indicated that truancy can lead to criminal activities and it is an opportunity for students to get involved in delinquent activities related to violence, alcohol, and drugs.

Psychopathology of School Refusal Behavior

As mentioned previously, youth with school refusal behavior often demonstrate internalizing and externalizing disorders. Students who exhibit school refusal behavior often meet diagnostic criteria for *Diagnostic and Statistical Manual of Mental Disorder-Fifth Edition* (DSM-5; American Psychological Association [APA], 2013) disorders such as social anxiety disorder, separation anxiety disorder, generalized anxiety disorder, panic disorder, selective mutism, oppositional defiant disorder, and depression.

Kearney and Albano (2004) found that of children who demonstrated school refusal behavior, 22.4% presented with social anxiety disorder; 10.5% presented with generalized anxiety disorder, and 8.4% presented with oppositional defiant disorder. Other diagnoses included 4.9% with depression profiles, 4.2% with specific phobia profiles, and 3.5% of social anxiety disorder. Furthermore, based on a review of seven studies examining diagnoses associated with school refusal, Kearney (1993) reported an estimated depression and school refusal comorbidity rate of 31.4%. Another unique population that has been studied includes those individuals with Gender Identify Disorder. Terada and colleagues (2012) found that the prevalence of school refusal was 29.2% of the total sample. Additionally, the researchers found that school refusal was more frequent among gender identity disordered patients with divorced parents rather than those patients with intact families.

Consistent with other researchers, a community study conducted by Egger, Costello, and Angold (2003) found similar results regarding the link between school refusal behavior and psychiatric disorders. Egger and colleagues found that school refusal was strongly associated with, but not synonymous with, psychiatric disorders. In their study, three quarters of the children with pure anxious school refusal, defined as those who stay home from school because of fear or anxiety, and those with pure truancy, defined as those who skip school because of a lack of interest in school and/or defiance of adult authority, did not meet criteria for any psychiatric disorders. Participants who were considered with purely anxious school refusal were associated with depression and separation anxiety .However, pure truancy was associated with oppositional defiant disorder, conduct disorder, and depression. In contrast to participants with pure anxious school refusal or with pure truancy school refusal, 88.2% of participants who demonstrated a mixed profile had a psychiatric disorder.

Risk Factors and Protective Factors for School Refusal Behavior

As with many other behaviors, there are general risk factors that increase the likelihood of the behavior to occur and persist. Wimmer (2011) described risk factors as environmental conditions that placed students at risk for school refusal and truancy. Protective factors are described as supports that reduced the probability of school refusal and truancy. Wimmer (2011) further broke down risk and protective factors into categories including child and adolescent variables, parent and family variables, poverty and homelessness, school climate and peer variables, and community variables.

Child and adolescent variables. Variables within the child and adolescent category include a history of psychiatric disorders such as anxiety and depression, lack of confidence, poor coping strategies, temperament, increased dependency on parents, age, academic failures and grade retention, as well as transitions and significant events (Kearney & Spear, 2013; Wimmer, 2011). As previously mentioned, many youth who demonstrated school refusal behavior also had a comorbid psychiatric illness (Egger, Costello, and Angold, 2003; Kearney, 1993; Kearney and Albano, 2004; Terada et. al., 2012). In addition, a lack of confidence can also affect student absenteeism. King and colleagues (2000) found that students with emotionally-based absenteeism often lacked confidence in their ability to cope with stressors in their lives. Conversely, findings indicated that decreasing emotional distress and improving self-efficacy had positive effects on youths' wellbeing. Temperament has also been linked to increased emotionally-based school absenteeism (King, et al., 1995). The age of an individual has also been found to affect absenteeism. Kearney and Albano (2007) found that younger children had a tendency to refuse to attend school in order to gain attention from parents and caregivers and to avoid situations that produced negative feelings. These researchers also found that adolescents have a tendency to fall into the other two functions, escape and tangible reinforcement. In this instance, the adolescents tended to escape aversive social situations or seek tangible reinforcement outside of school, such as sleeping, watching television, or hanging out with friends. Another factor, identified by Chang and Romero (2008), found with academic failures and grade retention, there was a link between student absenteeism and limited academic progress. Chronic early absence in kindergarten was found to predict the lowest levels of academic achievement at the

completion of fifth grade, especially for Latino and low-income students who had limited resources. At the middle school level, attending school less than 90% of the time in sixth grade increased the chances that a student would not graduate (Balfanz, Herzog, & Mac Iver, 2007). Furthermore, students with higher rates of excused or unexcused absences was also significant. Students who had a higher rate of unexcused absences also had a higher rate of deficits in reading and math, as compared with students with a higher rate of excused absences (Gottfried, 2009). However, the researcher hypothesized that this may be due to parental factors related to the type of absence. Students with many excused absences may have parents who attempt to prevent truancy and care about their children's education versus parents of students with unexcused absences who may not put as much value into education or may not focus on reducing truancy.

Parent and family variables. There are many parent and family variables that influence school refusal behavior. These include parent psychiatric illnesses, maternal depression, highly anxious parents, family interaction patterns, parenting style, parental substance abuse, child abuse, parent incarceration, foster care, and teenage pregnancy (Kearney & Spear, 2013; Wimmer, 2011). Additionally, some factors that can be risk factors or protective factors include parental education levels, participation in religious services, and parental expectations regarding academics, homework help, school involvement, and salience of education (Wimmer, 2011). When parents participated in their child's education, (i.e., monitoring homework, reading ability, grades, achievement scores, and courses and attend Parent Teacher Association meetings) the probability of truancy decreased (Epstein & Sheldon, 2002). Additionally, Kleine (1994) found that children and adolescents from single-parent households demonstrated higher rates of

absenteeism and truancy than those with two-parent households. In a review of literature, conducted by Bell, Rosen, and Dynlacht (1994), the researchers cited many family-relationship factors that positively correlated with truancy rates. These variables included socioeconomic status, family attitudes regarding education, parental knowledge of truancy, parental situations, parenting skills, and child abuse and neglect. Similarly, children and adolescents whose parents demonstrated a permissive parenting style, i.e., the children and adolescents gain autonomy in the decision-making, were more likely to engage in truancy (Rohrman, 1993). Therefore, weak parent-child relationships and limited parental involvement in their children's education, as well as parental alcoholism, drug abuse and parental violence were associated with higher levels of truancy (Kleine, 1994) (Rumberger, et al., 1990). Furthermore, many parents of school-refusing children actually experienced heightened levels of stress, anxiety, and depression (Tonge, King, & Heyne, 1998). Given these significant factors, children and adolescents with many dysfunctional family dynamics often live in poverty and may be homeless.

Poverty and homelessness. The poverty and homelessness category involves parental financial stressors, lack of adequate health care, lack of affordable housing, frequent school transfers, lack of required documentation for school enrollment, and transportation problems (Kearney & Spear, 2013; Wimmer, 2011). Homelessness is also a significant barrier to school attendance for children because many school districts require certain documentation as prerequisites to enrollment. Additionally, frequent relocation, financial costs, inaccessibility to transportation, inadequate clothing and school supplies and school concerns about liability also represent substantial barriers to school enrollment for homeless families (US Department of Education, 2002). According

to the US Department of Education, 87% of homeless school-aged children and adolescents were enrolled in school, but only 77% of these individuals attended school regularly. Regarding poverty, students from families of lower socioeconomic status, who may or may not receive free and reduced meals (FARMS) have higher levels of absenteeism and truancy (Kleine, 1994; Balfanz & Byrnes, 2012). Homelessness, housing instability, family obligations such as caring for younger siblings or elderly family members, and lack of a safe path to school have also been shown to be poverty-related barriers that prevented students from consistently attending schools (US Department of Education, 2004; Henry, 2007; Reid, 2005).

School climate and peer variables. The climate of a school that a student attends can affect social and emotional well-being, as well as the likelihood of wanting to come to school. Some variables in this category include school violence and victimization, cyberbullying, physical and emotional harassment or violence due to sexual identity, culturally responsive practices, ineffective attendance procedures, and harsh discipline practices (Kearney & Spear, 2013). Some specific factors within student engagement and connectedness can be considered both risk factors and protective factors. According to the National Center for Education (2006), statistics indicated that six percent of students avoided a school activity in the previous six months due to fear of attack or harm. Victims of bullying displayed higher rates of absenteeism than their peers and were 2.1 times more likely than other students to feel unsafe at school and repeatedly missed school to avoid being bullied (Dake, Price, & Telljohann, 2003; Glew, Fan Katon, Rivara, & Kernic, 2005). Peer interaction and support can have a great effect on youth's school refusal behavior. These variables include spending time with peers not interested

in school, spending time with peers who reinforce one another's risky behavior, and having few or no friends at school (Wimmer, 2011). Another key variable related to student engagement involves how schools address diversity issues, such as conveying respect for the culture and traditions of families and using interpreters to help break down communication barriers. Students who attended schools that did not address these variables often felt disengaged and alienated, leading to truancy (Henry, 2007). Conversely, student engagement and connectedness have proven to be protective factors. Students who felt connected and accepted in their schools had a greater chance of being engaged and successful in school (Kortering and Christenson, 2009). Students need to feel connected to adults and peers at school. They need to feel as if they belong, are cared for, and are noticed as individuals. The school should be another community for students.

Community variables. The community that the youth grow up in can also have an effect on their willingness to attend school. Variables included in this category are living in a dangerous neighborhood and the lack of community resources. Children and adolescents who lived in disorganized, unsafe, or unsupportive neighborhoods that included poor adult supervision of attendance and high rates of child self-care were at substantial risk for absenteeism (Chapman, 2003; Crowder & South, 2003; Henry, 2007; Reid, 2005). Wimmer (2011) indicated that living in dangerous neighborhoods caused students to stay home from school because of fear of having to make their way to and from school. Furthermore, a lack of community resources also affected students and their family's ability to obtain health care and mental health services (Chang & Romero, 2008). There is little research, other than this information, on the influence of community variables as it relates to school refusal behavior.

Assessment of School Refusal Behavior

As with any evaluation of a problem, the use of a multi-modal assessment is warranted. This assessment may include a thorough record review, observations, interviews, behavior rating scales, functional behavioral assessment, as well as cognitive and academic achievement testing. The evaluation tools should be carefully selected to ensure that they are psychometrically sound and appropriate for the referral. In the end, the various assessment tools need to be analyzed individually and collectively in order to make a data-based decision regarding the youth.

Record review. One of the first methods of conducting a school refusal assessment is to review a student's record thoroughly. The record review needs to encompass a wide range of records including schooling, family, medical and developmental background, psychiatric, attendance, and disciplinary history. One factor that can be obtained from a thorough record review is the number of schools attended. According to Wimmer, 2010, school refusal has been found to occur for a number of reasons, but one in particular is changing schools. Having to start over in a new school, with new teachers, and new peers can be very daunting for students. Other factors to examine include, report card grades, attendance history reports, state-wide assessment data, disciplinary records, referrals to Student Support Teams or Individual Education Program teams, history of school-based social worker or counseling services, any previous academic or psychological evaluations, and history of illnesses or injuries. According to Kearney and Spear (2013), the assessment of school refusal behavior should include a review of attendance and academic records. Attendance reports may provide data about occurrences of tardiness and partial and complete absences.

Furthermore, attendance records are valuable for informing parents about the severity of a child's absenteeism and for elucidating contradictory reports about how much school a child has actually missed. Records also provide important information about a student's grades and current academic status. If a child has missed substantial amounts of educational time, has accrued a significant amount of make-up work, or has failed to earn necessary academic credits, the school team should assess the likelihood that the student will have failed the school year and whether or not trying to achieve full-time attendance is worthwhile. A plan may be developed to modify class schedules or make-up work procedures to accumulate some academic credit, link the remainder of the school year to summer school, or pursue alternative educational settings. The combination of these records can give the examiner a good foundation for the rest of the evaluation.

Interviews. It is also important to interview various informants that work with the child, both in school and at home; these include administrators, counselors, psychologists, social workers, school secretaries, classroom and special area teachers, cafeteria workers, teaching assistants, and the child's parents. These individuals would be able to provide insight into the student's academic, social, emotional, and behavioral functioning. Additionally, Kearney and Spear (2013) reported that an interview should identify relevant developmental, medical, and mental health history of the student; it should assess fearfulness about attending, medication use, parental responses to absences, and the length and severity of absences, and develop fear ratings for various school-based situations. Wimmer (2011) suggested posing questions to parents about their awareness of the absences and the effects of the absences on the child's academic progress. Additionally, risk factors, as identified in the previous sections, should be explored to

gauge the level of risk for the child who is demonstrating school refusal behavior. Furthermore, the examiner should explore behavioral and emotional manifestations in school that may be related to the refusal behavior. This would lay the groundwork for the functional behavioral assessment.

Behavior rating scales. Parent, teacher, and self-report rating scales are imperative to assess the level of behavioral and emotional development. The examiner should administer both broadband and narrow-band scales. The broadband measures would allow the examiner to screen for areas of concern. Furthermore, broad-band measures may be administered to identify behavioral issues that relate more closely to the truancy aspects of school refusal behavior. Examples of broad-band measures that the examiner could provide are the Behavior Assessment System for Children- Third Edition (BASC-3; Kamphaus & Reynolds, 2015), the Conners Comprehensive Behavior Rating Scale (Conners CBRS; Conners, 2008), or the Child Behavior Checklist (CBCL; Achenbach & Rescorla, 2001). These scales can provide more insight on behaviors related to oppositional defiant disorder, conduct disorder, and social maladjustment. Subsequently, the examiner can administer more narrow-band scales to address concerns in greater detail. Some examples of narrow-band measures for anxiety are the Revised Children's Manifest Anxiety Scale-Second Edition (RCMAS-2; Reynolds & Richmond, 2008) and the Beck Anxiety Inventory (BAI; Beck, Steer, & Brown, 1996). These scales focus on various aspects of anxiety in order to hone in on the reason for a student's anxiety. To look further at depression, the examiner can complete scales such as the Childhood Depression Inventory- Second Edition (CDI-2; Kovacs, 2011) and the Reynold's Childhood Depression Scale- Second Edition (RCDS-2; Reynolds, 2010) or

Reynold's Adolescent Depression Scale- Second Edition (RADS-2; Reynolds, 2002). These scales will focus on the type of depression issues that a student is exhibiting. Obtaining ratings from teachers and parents allows the examiner to see the similarities and differences in the child's behavior across multiple settings. According to Kearney (2003), many clinicians utilized child self-report scales of internalizing behaviors and/or parent/teacher checklists of externalizing behaviors. Researchers also examined attendance, distress, and self-efficacy ratings, clinician ratings of functioning, family functioning, and diagnostic remission rates (Bernstein et al., 2000; Heyne et al., 2002; King et al., 1998; Last et al., 1998). Other than attendance, however, these dependent measures are not wholly specific to school refusal behavior. The scales are designed to provide clinicians with a profile of maintaining factors for school refusal behavior as part of a comprehensive functional analysis. The results of this analysis may then be used to help determine treatment direction.

For a more specific measure of school refusal behavior, Christopher Kearney developed the School Refusal Assessment Scale- Second Edition (SRAS-2). The SRAS-2 can be utilized to identify the function of or reason for a student's absenteeism (Kearney & Albano, 2007). The SRAS-2 is a 24-item questionnaire that requires respondents to answer questions based on a six-point Likert-type scale ranging from 0 (never) to 6 (always). Both the parent and the child versions contain six questions relating to the four functions or motivations for school refusal behavior (Wimmer, 2011). Kearney and Spear (2013) indicated that a profile of scores allowed clinicians to form a hypothesis about the reasons why a child continued to refuse school, but the scale should be utilized in conjunction with other measures for confirmation. Haight and colleagues (2011)

conducted a confirmatory analysis of the SRAS-2 and found that the scales were useful for quickly identifying a profile of functional contributions to a child's absenteeism.

Functional behavioral assessment. The functional behavioral assessment (FBA) is another key concept of the evaluation of the school refusal behavior. Anderson, Rodriquez, and Campbell (2015) describe a functional behavior assessment as a pre-intervention assessment used to develop a hypothesis about environmental variables that trigger and maintain problem behavior. Scott et al. (2008) distinguished between an "efficient" (i.e., an indirect and simplified approach for traditional classroom application) and a "formal" (i.e., a direct approach over multiple observational periods) functional behavior assessment. An "efficient FBA "would provide anecdotal and quantitative data regarding a student's behavior. This would allow the school team to hypothesize the function of the school refusal behavior. According to Van Acker, et al. (2005), the sources of indirect methods of data collection include student records, student interviews, parent interviews, teacher interviews, behavioral checklists, and permanent products. The "formal FBA" is more experimentally based, during which the team would evaluate the hypothesis through structural or functional analysis. Direct methods of data collection include systematic and non-systematic data collection and direct observations of teacher, student, and peer behavior across multiple settings and individuals (Van Acker et al., 2005). The functional behavior assessment, in conjunction with the School Refusal Assessment Scale-Second Edition (SRAS-2), will help to determine the function or functions of a student's behavior. With regard to school refusal behavior, the key aspects of this assessment involves the synthesis of the various data sources (e.g., record review, interviews, observations, parent and teacher reports, behavior rating scales, ABC data,

and the SRAS-2). As part of the functional behavior assessment, observations are especially important. Kearney and Spear (2013) reported that behavioral observation for school refusal behavior could be valuable for obtaining information about form and function of school refusal behavior. These observations may include parent-child interactions prior to required classroom attendance, the student's performance during evaluative tasks at school, child–peer interactions, attention-seeking behavior such as calling parents repeatedly, child departing school early, transitions between classes, and how a child responds to offers from others to miss school. Such observations may help confirm the function of a child's school refusal behavior. Behavioral observations are also useful for determining the extent to which a child can approach school and/or assume full-time attendance. These data sources will allow the examiner to target a function or functions in order to develop a behavior intervention plan.

Standardized testing. The last aspect of an evaluation is standardized testing. Standardized, norm-referenced assessments involve a cognitive and academic achievement battery. These assessments are used to evaluate a student's cognitive functioning and basic psychological processes as well as a student's achievement in the areas of math, reading, and writing. It may be necessary to have an understanding of a student's cognitive and academic abilities to ensure that his or her refusal to attend school is not due to an undiagnosed learning disability.

Treatment of School Refusal Behavior

With the use of the evaluation findings, especially the functional behavior assessment and the School Refusal Assessment Scale-Second Edition (SRAS-2), a treatment plan for the youth can be made. Overall, there is very limited evidence for any specific treatment program that is effective with school refusal behavior. However,

cognitive behavioral therapy appears to be the most effective, relatively, according to the current literature (Maynard, et al., 2015). Furthermore, most studies measured only immediate effects of interventions. There was only one study in Maynard et al.'s review that reported comparative longer-term effects on both increase in attendance and decrease in anxiety. Therefore, there is limited evidence that indicates whether or not treatment effects are maintained. Although there is a lack of evidence to support these treatments, it is clear that in the absence of treatment, most students who demonstrate school refusal behavior continue to display problematic school attendance and emotional distress (King, Tonge, Heyne et al., 1998). Therefore, significant adverse consequences may occur in the short- and long-term. At this point, the two prominent forms of treatment that are used with children and adolescents is clinical and pharmacological treatment.

Clinical treatment. Clinical interventions for problematic school absenteeism has primarily focused on reducing symptoms associated with school refusal behavior, especially anxiety and depression (Kearney, 2008). Clinical intervention may include cognitive behavioral therapy, play therapy and family therapy. The most commonly studied interventions for school refusal are behavioral approaches and cognitive behavioral therapy (CBT). The overarching aim of these interventions is the reduction of students' emotional distress and an increase in school attendance to help students follow a normal developmental pathway (Maynard, et al. 2015). Kearney (2008) indicated that behavioral interventions included exposure-based interventions, relaxation training, and/or social skills training with students and contingency management procedures with the parents and school staff. Cognitive behavioral therapy manuals focused attention on the identification and modification of maladaptive cognitions that may have maintained

students' emotional distress and absenteeism. In a study conducted by Heyne, et al. (2011), improvement in school attendance after cognitive behavioral therapy was accompanied by significant reductions in self-reported school-related fear and self-reported anxiety. Parent reports of adolescent anxiety corroborated the adolescents' self-reports and revealed further reduction in anxiety at follow-up. Half of the adolescents were free of any anxiety disorder at follow-up. In a review of a number of studies involving cognitive behavioral therapy only or cognitive behavioral therapy plus medication interventions, researchers found, on average, positive and significant effects on attendance compared with control group effects on anxiety at post-test (Maynard, et. al., 2015). Within cognitive behavioral therapy treatment, one of the first stages is psychoeducation. In a study conducted by Last et al. (1998), the researchers randomly assigned children diagnosed with anxiety-based school refusal to a cognitive behavioral therapy group and to an attention placebo control group. The cognitive behavioral therapy group were graduated to *in vivo* exposure and training in the use of coping self-statements; however, the attention placebo control group received educational support therapy. The participants learned how to distinguish between fear, anxiety, and phobia and kept a daily diary. The results of the study found that both interventions resulted in statistically significant improvements. The researchers hypothesized that the participants in the attention placebo group made significant improvements because they were able to modify their negative self-statements even without being directly taught the strategies. The study supported using psychoeducation about anxiety and school refusal as one component of the intervention for students who demonstrated school refusal behavior.

Regarding other clinical treatment therapies for school refusal behavior, there is limited research. One study using dialectical behavior therapy, conducted by Chu, Rizvi, Zendegui, and Bonavitacola (2015), incorporated the Dialectical Behavior Therapy for School Refusal (DBT-SR) program; this incorporated a multi-modal approach including web-based coaching i.e., active, real-time skills' coaching to children and parents, in the home during the morning hours. In this pilot study, the researchers found that this method was reasonably feasible and acceptable to clients and therapists, and that web-based coaching provided incremental, unique benefit. However, the researchers indicated that participant recruitment caused many difficulties and that the research seemed promising; however, it needed further development.

Medical and pharmacological treatment. The literature is very much limited with regard to efficacy of pharmacological treatment for school refusal behavior. Medical interventions are available for youth who demonstrate school refusal behavior; however, the focus is mainly on those who demonstrate anxiety-based problems such as generalized, social, or separation anxiety. Pharmacological therapy for children and adolescents who demonstrate school refusal behavior have included, primarily, tricyclic antidepressants, selective serotonin reuptake inhibitors (SSRIs), and other pharmacological agents (Heyne, et al. 2001). Pharmacological treatments are commonly employed although empirical support for their use is limited. Tricyclic antidepressants and selective serotonin (5-hydroxytryptamine; 5-HT) reuptake inhibitors are the more commonly used agents, with the latter having fewer associated adverse effects. It is suggested that the first line of treatment should be cognitive behavioral therapy, with

simultaneous or subsequent pharmacological treatment contingent upon the response to the behavioral therapy (Heyne, et. al. 2001).

Interventions by function. Given the fact that functional analyses are conducted to determine the reasons why children and adolescents are not attending school, it is important to identify strategies that are effective for students in each function. Kearney (2008), with the support of other colleagues, identified prescriptive intervention strategies for youth who refuse to attend school for the four functions mentioned earlier. These functions cover all youth who refuse to attend school. Effective, specific intervention packages can be identified, based on assessment data that include the School Refusal Assessment Scale-2 scores, interviews, direct observations, and other information. With regard to the avoidance and escape functions, interventions include psychoeducation regarding anxiety and its components and somatic management techniques (relaxation training and deep belly breathing), gradual re-exposure to the school setting, using anxiety and avoidance hierarchy and self-reinforcement gain. In addition, some escape function interventions include cognitive restructuring to modify irrational thoughts and the practice of coping skills in real-life social and evaluative situations. Regarding the attention function, the intervention involves modifying parent commands toward brevity and clarity, establishing a set morning routine prior to school as well as daytime routines as necessary, established rewards for attendance and punishments for nonattendance, and forced school attendance in specific cases. Last, for the tangible reinforcement function, interventions involve contingency contracting that involves incentives for attendance and punishments for nonattendance, establishment of times and places for family members to negotiate problem solutions, communication skills training, escorting of the youth to

school or class, increasing the monitoring of attendance, and peer refusal skills training (to refuse offers from others to miss school). (Kearney, 2002; Kearney, Pursell, & Alvarez, 2001; Kearney & Silverman, 1999; Moffitt, Chorpita, & Fernandez, 2003). Given that specific interventions may be appropriate, based on the targeted function, it is imperative to understand how school staff perceive absenteeism. If an incorrect function is identified, students may receive an inappropriate intervention leading to further misperception.

School Staff's Knowledge and Perception of School Refusal Behavior

There is very limited research on school personnel's perceptions of students who exhibit school refusal behavior. Cooper and Mellors (1990) conducted surveys with 26 teachers in England on their perceptions of school refusal behavior. The researchers found that teachers were able to distinguish students who demonstrate school refusal from truant students. However, they perceived students and adolescents as having lower self-esteem than the students' perceptions of their own self-esteem. One concern with this research, however, is that the perceptions of teachers who were measured worked in a specialized school for students with significant absenteeism. Torrens-Salemi (2006) conducted her dissertation research on school personnel's perception of school refusal behavior. She found that most personnel categorized the behavior of school refusal based on motivation or reason, as well as delineating it according to certain elements. The major categorizations included fearful school refusal (school phobia), defiant school refusal (truancy-like), separation anxiety, illness based refusal, and emotionality based school refusal (anxiety or depression). Grade level, transitions in school, legitimacy, and absenteeism patterns emerged as key elements that personnel used to describe and further

delineate school refusal behaviors. Another important aspect of Torrens-Salemi's research was the descriptions of students who refuse school. Personnel explained students' experiences of refusal as being driven by internal or external forces. Parents were viewed as a cause, enabling factor, or an influence on students' refusal behavior. Furthermore, it was assumed that parents of students from a low-income family devalued education. Last, participants speculated about students' perceptions of reality, particularly in cases of bullying. Torrens-Salemi found nine typifications of students, or the collective descriptions that emerged from school personnel's stories about students who refused school. The overarching dynamics of these typifications included parental control, parental awareness, student locus of control, blame, and victim status. The implication of these typifications is that they influence how personnel react to students they encounter, assisting personnel in deciding who deserves help or who deserves punishment, thus having implications for intervention and policy. Torrens-Armstrong, McCormack Brown, Brindley, Coreil, and McDermott, (2011) later indicated that the descriptive features of students who refused to attend school influenced how personnel reacted to students they encountered, particularly in deciding which students needed help versus those who needed discipline. Another interesting finding from Torrens-Salemi's research was that only more specially trained personnel (e.g., psychologists) acquire research on school refusal. It does not tend to be disseminated among other school personnel.

CHAPTER 3

METHOLODOLGY

This study employed a quantitative research design examining school personnel's knowledge and perceptions of school refusal behavior. School personnel were asked to complete a questionnaire examining knowledge and perceptions regarding school refusal behavior, the level of knowledge in the various domains (risk and protective factors and functions) of school refusal by role, distinction of truancy versus anxiety-based school refusal behavior, and the need for professional development regarding school refusal behavior. Additionally, mental health professionals' knowledge was obtained in the areas of assessment and treatment.

Participants

There were 500 participants who responded to the survey. Of the 500 respondents, 11 respondents did not meet the inclusion criteria for the survey. Of the 489 respondents, 260 respondents answered the demographic questions. Regarding the primary role of the respondents, 269 respondents indicated their primary roles. Therefore, the analyses were limited to the 269 respondents. There were 148 respondents who were considered mental health professionals (school psychologists, school counselors, school social workers, and pupil personnel workers) and 121 participants who were considered non-mental health professionals (general education teachers, special education teachers, administrators, and school nurse). There were 11 individuals who responded to "other" as his or her specific role. Examples of the respondents' "other" specifications included roles such as music teacher, resource teacher, and instructional support teacher. None of the individuals indicated a mental health professional role; therefore, their responses were included with the non-mental health professionals. Information regarding demographic data for

participants is presented in table 1. Additionally, demographic information was further specified by the role that the respondent identified, which can be found in table 2. The school personnel also responded to whether or not they had courses, lectures, or professional development devoted to learning about school refusal behavior or had engaged in self-study of school refusal behavior; this can be found in table 3.

Table 1

Demographic Information of Mental Health and Non-Mental Health Professionals

Demographic Variable	*n*	Mental Health	*n*	Non-Mental Health
Gender				
	5	3.5% male	5	4.2% male
	137	96.5% female	114	95.8% female
Age				
21-25 years old	4	2.8%	3	2.5%
26-30 years old	28	19.8%	15	12.6%
31-35 years old	30	21.3%	17	14.3%
36-40 years old	28	19.8%	19	16%
41-50 years old	39	27.6%	45	37.8%
51-60 years old	10	7.1%	15	12.6%
> 60 years old	2	1.4%	5	4.2%
Geographic Region				
Northwest	36	25.5%	16	13.6%
Midwest	28	19.8%	8	6.7%
South	56	39.7%	80	67.8%
West	21	14.9%	14	11.9%
Level of Education				
Bachelor’s Degree	1	0.7%	15	12.6%
Master’s Degree	39	27.6%	88	73.9%
Specialist	73	51.8%	11	9.2%
Doctorate	28	19.9%	5	4.2%

Work Setting				
Public Elementary School	104	73.2%	81	68.1%
Public Middle School	65	45.8%	28	23.5%
Public High School	60	42.3%	15	12.6%
Private Elementary School	6	4.2%	5	4.2%
Private Middle School	4	2.8%	4	3.4%
Private High School	1	0.7%	1	0.8%
Nonpublic School	10	7%	4	3.4%

Table 2

Percentage of Respondents from each Identified Role

Role	*n*	Percentage Identified
Non-Mental Health Professional		
Administrator	45	37.2%
General Education Teacher	35	28.9%
Special Education Teacher	26	21.5%
Other	11	9.1%
Nurse	4	3.3%
Mental Health Professionals		
School Psychologist	133	89.9%
School Social Worker	8	5.4%
School Counselor	5	3.4%
Pupil Personnel Worker	2	1.4%

Table 3

Percentage of Respondents who have Engaged in Professional Learning

Training	*n*	Mental Health	*n*	Non-Mental Health
Some Lecture on School Refusal	42	29.6%	18	15.1%
Professional Development on School Refusal	55	38.7%	31	26.3%
Self-Study about School Refusal	95	66.4%	60	33.6%

The participants in this study were school personnel from across the United States. School personnel included individuals who worked in a school setting and who identified as a school psychologist, pupil personnel worker, school social worker, school counselor, general education teacher, special education teacher, school administrator, or school nurse. The participants worked in a public or private school district that included

grades pre-kindergarten through twelve. Additionally, individuals who worked in a non-public setting (a setting where students with severe and profound needs that cannot be serviced in their public school are placed and which is funded by their school system) were included. Participants in the study were at least age 21, of any race, ethnicity, or gender; and had at least a bachelor's degree. Participants lived in areas across the United States. In order to recruit participants, the link to the survey was placed on social media sites and was sent to any publicly available e-mail addresses of potential participants.

Measures

The study incorporated the use of an online survey that was developed for the purposes of this study and a link to the survey was used to disseminate to the potential participants. The survey was created to obtain information regarding risk and protective factors, the four-function model of school refusal behavior, and the assessment and treatment of school refusal behavior. Prior to the dissemination of the survey and for the purpose of collecting research, the study was provided to three experts to review the survey questions in order to determine that the language of the survey items was appropriate and was relevant to the targeted respondents. Edits to the survey items were made based on feedback from the expert review panel. The final survey was reviewed again by the same experts prior to the use for this research.

All participants were informed that they and, therefore, their answers were anonymous. The survey was broken down into domains of knowledge and perception, with questions presented to address each domain. The questions helped to identify the level of knowledge the participants had in each domain in order to further drive the need for professional development and in what specific areas of knowledge. Furthermore, the

survey questions aided in understanding the school personnel's current perceptions as well as their perceptions of the climate of their school with regard to students who demonstrated school refusal behavior. Following the content of the survey, the participants provided demographic information, including: age, gender, geographic region, level of education, type of setting in which they currently work, role in the school setting, number of years working in the role, and number of students that they have worked with who exhibited school refusal behavior.

Procedures

A Survey Monkey was developed in order to create the measure that was used in this study. The measure was given to three experts in the field in order to determine the reliability and validity of the study as well as to determine how long it would take to complete the questionnaire. After this information was identified, the Survey Monkey link to the questionnaire was disseminated through email and online postings. The recruited participants clicked on the link to the questionnaire. This link provided a brief introduction to the study, explained to potential participants that the information provided was anonymous and no identifying information was collected. Subsequently, the participants were required to answer eligibility questions in order to determine if they were eligible to partake in the study. After participants were determined to be eligible to partake in the study, they identified whether or not they wanted to continue their participation in the study by selecting "I agree to continue my participation" or "I wish to discontinue." The participants then began the survey by answering questions regarding risk and protective factors and functions of school refusal behavior. Participants answered questions regarding their perceptions of school refusal behavior, as well as their

perceptions of the climate of their schools, as it related to school refusal behavior. Next, participants were asked about their roles within the school setting. If they identified a mental health professional role, participants were provided with questions to measure their knowledge of assessment and treatment of school refusal behavior, followed by questions regarding demographic information. If participants identified a non-mental health professional role, they were provided with questions regarding demographic information. The investigator posted links to the survey via social media sources. These potential participants were also asked to share the link to the survey through their social media outlets. The survey became available on February 19, 2018 after approval was given by the Institutional Review Board of the Philadelphia College of Osteopathic Medicine. The survey was sent out a second time on March 7, 2018 in order to encourage additional participation across respondents' roles in the school setting. The survey closed on March 8, 2018 after the limit of 500 respondents was reached.

CHAPTER 4

RESULTS

Frequency and descriptive data from the School Personnel's Knowledge and Perception of School Refusal Behavior survey (Appendix) was utilized to compute and present information regarding perception of school refusal behavior, perception of school climate as it relates to school refusal behavior, and the level of knowledge among mental health professionals. Additionally, an independent samples t-test was conducted to identify differences between the mental health professionals' group and the non-mental health professionals' group as it relates to knowledge of risk and protective factors and the four-function model of school refusal behavior. Results related to each research question and hypothesis are provided in the following section.

Research Question 1

The first research question in the present study targeted the difference in the level of knowledge of school refusal behavior among school personnel. It was hypothesized that mental health professionals demonstrated a higher level of knowledge than non-mental health professionals regarding school refusal behavior, relative to risk and protective factors. Therefore, an independent samples t-test was conducted in order to compare the level of knowledge of mental health professionals and that of non-mental health professions, relative to risk factors and protective factors of school refusal behavior. Items related to risk and to protective factors of school refusal behavior were averaged and an independent samples t-test was conducted on mental health and non-mental health professionals who answered all four items, 135 and 114 respectively. From the statistical analysis, there was a significant difference in the level of knowledge

between mental health professionals (*M*=3.20, *SD*= .76) and non-mental health professionals (*M*= 2.91, *SD*= 1.1) with mental health professionals demonstrating more knowledge related to risk factors and protective factors of school refusal behavior; *t*(245)= 2.27, *p*= .024. Table 4 shows the percentage of mental health professionals and non-mental health professionals who responded correctly to each question related to risk factors and protective factors of school refusal behavior.

Table 4

Percentage of Respondent who Answered the Risk and Protective Factors Questions Correctly

Risk/Protective Factors	*n*	Mental Health	*n*	Non-Mental Health
School Climate Risk Factors	148	90.5%	121	86%
Child and Adolescent Risk Factors	135	87.4%	114	76.3%
Community Protective Factors	149	84%	120	68.3%
Parent and Family Risk Factors	147	60.5%	119	57.1%

It was also hypothesized that mental health professionals would demonstrate a higher level of knowledge than non-mental health professionals regarding school refusal behavior as it relates to the four-function model. Therefore, a second independent samples t-test was conducted in order to compare the level of knowledge of mental health professionals and of non-mental health professions relative to the four-function model of school refusal behavior. Similar to risk and protective factors, items related to the four-function model of school refusal behavior were averaged and an independent samples t-test was conducted on the mental health and non-mental health professionals who responded to all four items, 148 and 120 respectively. From the statistical analysis, there was no significant difference in the level of knowledge between mental health

professionals (*M*=1.47, *SD*= 0.94) and non-mental health professionals (*M*= 1.35, *SD*= 0.95) relative to the four-function model of school refusal behavior; *t*(266)= 1.004, *p*= .316. Table 5 shows the percentage of mental health professionals and non-mental health professionals who responded correctly to each question related to risk and protective factors of school refusal behavior.

Table 5

Percentage of Respondent who Answered the Four-Function Model Questions Correctly

Four-Function Model	*n*	Mental Health	*n*	Non-Mental Health
Alex's Function (Tangible)	148	43.2%	121	21.5%
Johnny's Function (Avoidance)	148	40.5%	120	59.2%
Sarah's Function (Attention)	148	33.1%	121	41.7%
Deshawn's Function (Escape)	148	29.7%	121	13.2%

Research Question 2

The second research question addressed the differences in the perception of school refusal behavior among school personnel. It was hypothesized that mental health professionals perceived school refusal behavior as an emotionally-based condition, as opposed to delinquent behavior. It was also hypothesized that non-mental health professionals perceived school refusal behavior as delinquent behavior, as opposed to an emotionally-based condition. When considering the perceptions of school personnel related to the behavioral differences in students who demonstrate school refusal behavior due to anxiety or depression, and students who refuse to attend school due to defiance, the results indicated that 27% of mental health professionals and 19% of non-mental health professionals agreed that there is no major differences. This indicates that most respondents in both groups were able to differentiate delinquent and emotionally-based

behavior as it relates to the behaviors of students. Regarding differences in students when considering the emotionality of their behavior, 8.1% of the mental health professionals and 6.7% of the non-mental health professionals agreed that there were no major differences, emotionally, in students who refuse to attend school due to anxiety or depression and students who refuse to attend school due to defiance. This, again, indicates that both groups were able to differentiate between delinquent and emotionally-based behavior. Of the mental health professionals, 92.9% disagreed that students who refuse to attend school due to anxiety or depression should be treated in the same as students who refuse to attend school due to defiance. Similarly, 89.9% of non-mental health professionals disagreed with the same statement. According to data shown in table 4, 91.9% of mental health professionals and 85.8% of non-mental health professionals disagreed that students who refuse to come to school use anxiety or depression as an excuse to stay home from school, when they are actually trying to get out of coming to school. Of mental health professionals, 52% disagreed and 29.1% agreed that student attendance, regardless of their reasons for refusing to attend school, would be improved if parents would force their students to attend school. Likewise, 44.2% of non-mental health professional disagreed; however, 36.6% of non-mental health professional agreed with the same statement.

It was hypothesized that mental health professional and non-mental health professionals would perceive the climate of their schools negatively, relative to the understanding and discipline of school refusal behavior. From Table 6, the data indicate that 33.1% of mental health professional disagreed and 51.3% agreed that students who refuse to attend school based on reasons related to anxiety or depression are treated the

same by administrators and other staff members as students who refuse to attend school due to defiance. Conversely, 55% of non-mental health professionals disagreed and 30.8% agreed to the same statement. Among mental health professionals, 74.3% and among non-mental health professionals, 65.5% agreed that they have heard people in their schools make statements or take actions that would suggest that they do not feel a student is missing school because of anxiety, but more so due to defiance. Of the mental health professionals, 54.7% agreed that staff in their schools take time to help determine the reason why a student is frequently absent from school; 68.1% of non-mental health professionals also agreed with the statement. Data from the respondents indicate that 70.3% of mental health professionals and 91.5% of non-mental health professionals agreed that staff in their schools are supportive of students who demonstrate financial difficulties and lack necessary resources to be successful in school. Furthermore, 50.7% of mental professionals agreed and 24.3% disagreed that staff in their schools are supportive of students who demonstrate anxiety-based school refusal behaviors. Similarly, 59.3% of non-mental health agreed and 20.3% disagreed with the same statement. From the data, it was also noted that 62.8% of mental health professionals agreed that they have enough knowledge to work with and support student with school refusal behavior and that they needed more training to be able to work with and help student with school refusal behavior. Regarding non-mental health professionals, 30.5% agreed that they had enough knowledge to work with and support student with school refusal behavior and 84.9% agreed that they needed more training to be able to work with and help students with school refusal behavior.

Table 6

School Personnel's Perception of School Refusal Behavior

Perception	Mental Health				Non-Mental Health			
	n	Strongly Disagree/ Disagree	Neutral	Strongly Agree/Agree	*n*	Strongly Disagree/ Disagree	Neutral	Strongly Agree/Agree
No behavior differences between emotionally-based school refusal and defiance	148	68.2%	4.7%	27%	121	71.9%	9.1%	19%
No behavior differences between emotionally-based school refusal and defiance	148	85.8%	6.1%	8.1%	120	87.5%	5.8%	6.7%
Emotionally-based school refusal should be treated the same as defiance	148	92.6%	3.4%	4.1%	119	89.9%	4.2%	5.9%
Anxiety and depression is used as an excuse to get out of school	148	91.9%	7.4%	0.7%	120	85.8%	11.7%	2.5%
If parents forced students to go to school, it would improve attendance regardless of emotional vs. defiance	148	52%	19.6%	29.1%	120	44.2%	19.2%	36.6%

Table 7

School Personnel's Perception of School Climate Related to School Refusal Behavior

Perception-School Climate	Mental Health				Non-Mental Health			
	n	Strongly Disagree/ Disagree	Neutral	Strongly Agree/Agree	*n*	Strongly Disagree/ Disagree	Neutral	Strongly Agree/Agree
Students with emotionally-based school refusal ARE treated the same as defiant students	148	33.1%	15.5%	51.3%	120	55%	14.2%	30.8%
People in my school make statements or take actions that suggest they feel students are missing school due to defiance	148	14.2%	11.5%	74.3%	119	21%	13.4%	65.5%
Staff take time to help determine the reason a student is frequently absent	148	29.1%	16.2%	54.7%	119	19.3%	12.6%	68.1%
School staff are supportive of students with financial difficulties and lack of resources	148	12.1%	17.6%	70.3%	118	4.2%	4.2%	91.5%
School staff are supportive of student who have anxiety-based school refusal	148	24.3%	25%	50.7%	118	20.3%	20.3%	59.3%
I feel I have enough knowledge to support student with school refusal behavior	148	19.6%	17.6%	62.8%	118	50.1%	18.6%	30.5%
I need more training to support students with school refusal behavior	148	14.9%	22.3%	62.8%	119	4.2%	10.9%	84.9%

Research Question 3

The third research question was specific to mental health professionals addressing the level of knowledge regarding the assessment and treatment of school refusal behavior. Table 8 displays the percentage of mental health professionals who agreed that the component listed was important to include in the assessment of school refusal behavior. In table 9, the data display the responses that participants indicated from each of the survey items in the assessment and treatment section of the survey. Bolded items indicate correct answers.

Table 8

Mental Health Professionals Agreement of Necessary Components of a Comprehensive Assessment

Comprehensive Assessment Components	*n*	Mental Health
Student's Mental Health	140	99.3%
Academic Functioning	140	99.3%
Health/Medical Factors	140	99.3%
Social Development	137	97.2%
Emotional Development	137	97.2%
Cognitive Functioning	119	84.4%
Parent's Mental Health	104	73.8%
Parenting Styles	96	68.1%

Table 9

Percentage of Respondents' Answers from Each Item of the Survey

Assessment and Treatment	*n*	Mental Health
Most important assessment component for School Refusal?		
Functional Behavior Assessment	**95**	**65.5%**
Interviews	43	29.7%
Record Reviews	4	2.8%
Cognitive Testing	2	1.4%
I do not know	1	0.6%

Why is cognitive testing important?		
To ensure school refusal is not related to another factor	**111**	**76.6%**
It is not important	25	17.2%
To identify the reason students miss school	5	3.4%
I do not know	4	2.%
Identify students' strengths	0	0%
Which rating scale helps determine the function of School Refusal?	**94**	**65.3%**
School Refusal Assessment Scale-Second Edition	33	22.9%
I do not know	14	9.7%
Behavior Assessment System for Children-Third Edition	2	1.4%
Beck Youth Inventories	1	0.7%
Childhood Behavior Checklist		
An FBA should include?		
Record review, interviews with parent, student, teachers; behavior checklist; and observations across settings	**117**	**80.7%**
Record review, interview with parent and teachers, behavior checklists, and an observation of a student	24	16.6%
Direct observation of a student	3	2.1%
Interview with parents and students	1	0.7%
I do not know	0	0%
Theoretical framework with greatest affects on School Refusal?	**71**	**49%**
Cognitive Behavior Therapy	36	24.8%
I do not know	28	9.3%
Solution Focused Therapy	7	4.8%
Dialectical Behavior Therapy	3	2.1%
Rational Emotive Behavior Therapy		
Treatment protocol with research base for School Refusal?		
Pharmacological and clinical treatment combined	**92**	**63.4%**
I do not know	31	21.4%
Clinical treatment	15	10.3%
Neither	7	4.8%
Pharmacological treatment	0	0%

Note. Bolded items indicate correct answers.

CHAPTER 5

DISCUSSION

The purpose of this study was to examine the knowledge and perception of school personnel regarding school refusal behavior. The study examined the differences in the level of knowledge between mental health and non-mental professionals related to risk and protective factors and the four-function model of school refusal behavior. This study also examined the differences between mental health and non-mental health professionals' perceptions related to school refusal behavior as an emotionally-based condition or delinquent behavior. Furthermore, the perceptions of the climate of the mental health and non-mental health professionals' work setting was examined as it related to the discipline and supports for students who demonstrated school refusal behavior. Last, the study examined the levels of knowledge among mental health professionals regarding the assessment and treatment of school refusal behavior. This study aimed to identify the level of need for additional professional development for mental health and non-mental health professionals regarding school refusal behavior and the type of professional development that is needed. A total of 148 mental health professionals and 121 non-mental health professional responded to the survey and indicated their roles within the school setting. The following sections discuss the findings of this study as they relate to the current research questions and hypotheses, the limitations of this study, clinical implications, and directions for future research.

Research Question 1

The first research question examined the level of knowledge of school refusal behavior among school personnel. It was hypothesized that mental health professionals

demonstrated a higher level of knowledge than non-mental health professionals regarding school refusal behavior as it relates to risk factors and protective factors. This study found that there was a statistically significant difference in the level of knowledge between mental health professionals and non-mental health professionals, with mental health professionals demonstrating more knowledge related to risk factors and protective factors of school refusal behavior, providing evidence to support hypothesis one. When comparing the data for the individual items on the survey, the majority of mental health professionals demonstrated knowledge and understanding of school climate risk factors, child and adolescent risk factors, and community protective factors. The majority of non-mental health professionals also demonstrated knowledge and understanding of school climate risk factors and child and adolescent risk factors. Both groups demonstrated inconsistent knowledge and understanding of parent and family risk factors. Regarding community factors, the majority of mental health professional demonstrated knowledge and understanding, but little more than half of the non-mental health professional demonstrated the knowledge and understanding. These findings are consistent with the hypothesis from this study. However, it is surprising to see that mental health professionals, who receive extensive training in mental health disorders, in risk factors and protective factors, have such limited knowledge of parent and family risk factors.

This study also found that there were no statistically significant differences in the level of knowledge of mental health and non-mental health professionals, relative to the four-function model of school refusal behavior, which was not in support of hypothesis two. Rather, mental health professionals and non-mental health professionals, equally, had very limited knowledge and understanding of the four-function model of school

refusal behavior. The percentage of respondents who answered the four-function model questions correctly from the mental health group ranged from 29.7% to 43.2%. Similarly, the percentage of respondents who answered the four-function model questions correctly from the non-mental health group ranged from 13.2% to 59.2%. Kearney, et al. (2004), found that school staff often perceive children and adolescents as exhibiting the fourth function of school refusal behavior, tangible reinforcement. Although there was no inclination to identify tangible reinforcement as the function for each scenario in the current study, the results are consistent with Kearney et al. (2004), which indicated that school personnel often lack the knowledge of the four-function model in order to identify, appropriately, the function of the student's school refusal behavior. Furthermore, the current study found that respondents from the mental health and non-mental health groups often confused the escape and avoidance functions. Additionally, respondents, regardless of the function of the behavior, often identified the function of the behavior as avoidance or escape. In reviewing demographic information of respondents who responded correctly to the four-function model items, there was a range of 30-40% of mental health professionals who responded correctly; however, non-mental health professionals' performances varied greatly. Furthermore, it was noted that respondents who did not attend professional development on school refusal behavior and or did not have courses on school refusal behavior performed better than respondents who did have these opportunities. However, it is unclear how recent or late or how much in-depth these courses or professional development programs were for respondents who did engage in these opportunities. Nonetheless, research from Torrens-Salemi (2006) found that only

more specially trained personnel (e.g., psychologists) acquire research on school refusal. It does not tend to be disseminated to other school personnel.

Research Question 2

The second research question addressed the differences in the perception of school refusal behavior among school personnel. It was hypothesized that mental health professionals perceived school refusal behavior as an emotionally-based condition and non-mental health professionals perceived school refusal behavior as a delinquent behavior. This study found that mental health professional and non-mental health professionals responded similarly on items related to the perception of school refusal behavior. More specifically, more than half of the school personnel in both groups disagreed that there were no behavioral differences in students who demonstrated emotionally-based school refusal behavior and students who demonstrated delinquent behavior. Furthermore, only about a quarter of school personnel in both groups agreed that there was no difference, behaviorally, between the two groups of students. This suggested that the two groups felt that they were able to distinguish the behavioral differences of students, regardless of the function of their behavior.

Regarding the emotionality of the students who demonstrated school refusal behavior, the majority of the school personnel in both groups disagreed that there were no differences, emotionally, between students who demonstrated emotionally-based school refusal behavior and the students who demonstrated delinquent behavior. This suggested that the two groups perceived that they were able to distinguish the emotionality of students regardless of the function of their behavior. Consistent with the findings from the current study, Coopers and Mellors' (1990) research on school personnel's ability to

distinguish emotionally-based school refusal and truancy found that teachers were able to clearly distinguish students who exhibited school refusal behavior and students who were truant. The current study found that the majority of the school personnel from both groups did not believe that the emotionally-based and delinquent school refusal behavior students should be treated the same. Furthermore, school personnel from both groups did not agree that students who demonstrate school refusal behavior used anxiety and depression as an excuse to get out of coming to school. Torrens-Salemi (2006) studied the perception of school refusal behavior among school staff and found that most staff categorized the behavior of school refusal based on motivation or reason, as well as delineating it according to certain elements. The major categorizations included fearful school refusal (school phobia), defiant school refusal (truancy-like), separation anxiety, illness based refusal, and emotionality based school refusal (anxiety or depression). Furthermore, Torrens-Armstrong et al. (2011) later indicated that the descriptive features of students who refused to attend school influenced how personnel reacted to students they encountered, particularly in deciding which students needed help versus those who needed discipline. These results are consistent with the results from the current study, indicating that school personnel were able to identify differences in students, emotionally and behaviorally, and that students should be treated, based on the function of their school refusal behavior.

Regarding school personnel's' perception of parental influences on student attendance, there was a variation in responses among groups. A little more than half of the mental health professionals and a little fewer than half of the non-mental health professionals disagreed that if parents forced students to go to school, it would improve

attendance regardless of whether or not the student demonstrated emotionally-based school refusal behavior or delinquent behavior. Furthermore, around 20% of the school personnel from both groups felt neutral about the statement and around 30% of school personnel agreed with the claim. This response indicates that regardless of the function of the school refusal behavior, a significant portion of the respondents attributed attendance factors to parental influence. These findings are consistent with research conducted by Torrens-Salemi (2006), who found that personnel explained students' experiences of refusal as being driven by internal or external forces. Parents were viewed as a cause, an enabling factor, or an influence on student's refusal behavior. Furthermore, it was assumed that parents of students from a low-income family devalued education.

It was also hypothesized that both mental health professionals and non-mental health professionals would perceive the climate of their school as negative, relative to the treatment and support of students who demonstrated school refusal behavior. This study found that half of the mental health professionals agreed that students with emotionally-based school refusal behavior are treated in the same manner as delinquent students. Conversely, about a third of the non-mental health professionals agreed with the same statement. Although, the majority of school personnel in both groups agreed that people in their schools made statements or took action suggesting that they felt students were missing school due to defiance, regardless of whether or not they demonstrated emotionally-based school refusal behavior or delinquent behavior. The study also found that more than half of the school personnel in both groups felt that staff took time to help to determine the reason why a student was frequently absent and were supportive of those students with emotionally-based school refusal behavior. Furthermore, most of the school

personnel felt that school staff were supportive of students with financial difficulties and students who lacked resources. This finding is important with regard to the prognosis for students who demonstrate school refusal behavior, given the findings from Kearney and Spear (2013) which indicated that the climate of a school that a student attends could affect the social and emotional well-being of students, as well as the likelihood of wanting to come to school. Some variables related to school climate include school violence and victimization, cyberbullying, physical and emotional harassment or violence due to sexual identity, culturally responsive practices, ineffective attendance procedures, and harsh discipline practices. As previously mentioned from Torrens-Armstrong et al. (2011), descriptive features of students who refused to attend school influenced how personnel reacted to students they encountered, particularly in deciding which students needed help versus those who needed discipline. The outcomes from Torrens-Armstrong et al. (2011) further supports the importance of the perception of school personnel as it relates to the climate of the school. More specifically, this indicates that the perception of the school personnel relative to the student's absences may affect how connected and safe the student feels about the school, which, in turn, affects attendance. Last, the study found that more than half of mental health professionals felt that they had enough knowledge to support students with school refusal behavior, but also indicated that they felt they need additional training to support students with school refusal behavior. For non-mental health professionals, half of the group felt that they did not have enough knowledge to support students with school refusal behavior; most of the group indicated that they needed more training to support students with school refusal behavior.

Research Question 3

The third research question was specific to mental health professionals and their level of knowledge regarding the assessment and treatment of school refusal behavior. This study found that the majority of mental health professionals demonstrated sufficient knowledge in the components of a comprehensive assessment of school refusal behavior. However, about a quarter of respondents did not indicate parents' mental health and parenting styles as necessary components of the assessment of school refusal behavior. The majority of mental health professionals were able to identify the components of a functional behavioral assessment and the importance of a cognitive assessment in the assessment of school refusal behavior. More than half of the mental health professionals were able to identify correctly that a functional behavior assessment was one of the most important assessment components of school refusal behavior. The most common incorrect response was an interview. Regarding the rating scale used for the assessment of school refusal behavior, most participants responded correctly, indicating the School Refusal Assessment Scale-Second Edition. The most common incorrect response was that the participants did not know the answer. These results are important, given the fact that Kearney and Silverman (1999) found that having an understanding of a comprehensive assessment including a thorough record review, observations, behavior rating scales, interviews, and functional behavior assessment help establish an effective plan of treatment that fits the individual (Kearney & Silverman; Kearney & Spear, 2013).

Regarding the treatment of school refusal behavior, the current study found that more than half of the mental health professionals were able to identify correctly that clinical and pharmacological treatment combined was the treatment protocol with the

most highly research basis for the treatment of school refusal behavior. The most common incorrect response was that participants did not know the answer. Fewer than half of the mental health professionals were able to identify correctly that cognitive behavior therapy is the theoretical framework with the greatest effect on school refusal behavior. The most common incorrect response was that the participants did not know the answer. Torrens-Salemi (2006) found that only more specially trained personnel (e.g., psychologists) acquire research on school refusal; generally, however, school psychologists, depending upon their program of study, do not receive a significant amount of coursework or research in the area of counseling. Furthermore, school psychologists' roles often involve more assessment than counseling, which may explain this outcome in the study.

Clinical Implications

Results from the current study indicated that mental health professionals demonstrated a higher level of knowledge regarding risk factors and protective factors than non-mental health professional, indicating that mental health professionals have a greater understanding of risk and of protective factors and may be better able to support students in the school setting. With the limited knowledge of risk factors and protective factors for non-mental health professionals, these school personnel may have more difficulty with early identification of and distinguishing between students who demonstrate emotionally-based school refusal behavior and delinquency, which may lead to inadequate or inappropriate treatment modalities and misperceptions about the students. Subsequently, these issues may lead to increased absenteeism and deficits in academic skills (Balfanz et al., 2007; Gottfried, 2009). Results from the current study

also suggested that school personnel from both groups had difficulty identifying parent and family risk factors, which may affect the early intervention of students who demonstrate school refusal behavior and also have significant parent and family risk factors. The fact that both mental health and non-mental health professionals demonstrated limited knowledge of parent and family risk factors indicates that both groups should receive additional training regarding this factor. This additionally supports the need for parent and family engagement in the school and collaboration among school staff and families. Past research supports the fact that weak parent-child relationships and limited parental involvement in their child's education are associated with higher levels of truancy as well as parental alcoholism, drug abuse, and domestic violence (Kleine, 1994; Rumberger et al., 1991).

The finding that mental health and non-mental health professionals have limited knowledge regarding the four-function model of school refusal behavior confirms that the personnel in various disciplines continue to misunderstand the functions of school refusal behavior. Limited understanding of the functions of school refusal behavior may make distinguishing between students who demonstrate emotionally-based school refusal behavior and students who demonstrate delinquent behaviors much more difficult and students may be wrongly identified. One of the major concerns as outlined by Cooper and Mellors (1990) is that labeling students by function can be problematic; once they are labeled as truant, disruptive, or exhibiting school refusal behavior, it can be very difficult for the student to lose or change the label. Furthermore, the label given determines a subsequent intervention plan. If a student is misidentified, this could affect the treatment he or she receives and, also, possible prognosis. Therefore, it continues to be necessary

that additional training and professional development should be provided to increase knowledge about school refusal behavior across disciplines.

Results regarding school climate indicate that school personnel will take time to understand their students in order to assist them in receiving support for emotionally-based conditions and advocate for support for the student and their families outside of the school setting. However, the results regarding the perceptions of mental health professionals on how students are disciplined and the perceptions of school personnel from both groups regarding comments or actions taken against students who demonstrate school refusal behavior suggests that there is limited consistency in practice when it comes to treating student with school refusal behavior. The inconsistency suggests that school personnel may believe they have an understanding, but ultimately may have misidentified student or hold a bias against students with high absenteeism. This misidentification or bias may hinder identification of an emotionally-based condition and could prolong or further intensify the student's negative emotions toward school stimuli. Furthermore, the comments or actions, especially from administrators, may add to misinformation within the school regarding a specific student and the reason for his or her absenteeism.

The finding that mental health and non-mental professionals lacked understanding of the four-function model of school refusal behavior, coupled with previous research from Torrens-Armstrong et al. (2011), regarding decisions about which students needed help versus which students needed discipline, reaffirms the need for additional training on the four-function model and school refusal behavior overall. This is further supported

by respondents in both groups identifying a need for additional training to support students with school refusal behavior.

In terms of assessment and treatment, results indicate that the majority of mental health professionals have the knowledge base to identify appropriate assessment procedures and treatment protocols. Conversely, however, mental health professionals demonstrated limited knowledge of the four-function model, indicating that additional training and professional development should be emphasized for functional behavioral assessments and proper identification of the function of behavior. In addition, further training around counseling-based techniques and their relationship to school refusal behavior may be necessary in order to address the results from this study regarding mental health professionals' difficulties with identifying the theoretical framework that has the greatest effects on school refusal behavior. These results suggest that mental health professionals may not have a good understanding of the counseling strategies that are effective for school refusal behavior and may not be fully equipped to support students who demonstrate school refusal behavior. It is important for mental health providers to have an understanding of assessment and treatment of school refusal behavior to support students, the students' families, and the school personnel who work with the students.

Limitations

There were a number of limitations in this study that required examination. The first limitation of this study relates to the generalizability of the results. Regarding gender, only 10 of the 261 respondents who responded to the gender question from the demographic section of the survey were male, suggesting that there was limited

representation from the male population. This limitation likely exists due to the demographics of the field of education overall. The ratio of women to men represented in the field of education is quite large. Regarding the identified roles within the mental health professionals and non-mental health professionals groups, 89.8% (*n*= 133) of the mental health professionals identified as school psychologists. There was limited representation from school counselors, school social workers, and pupil personnel workers. Furthermore, from the non-mental health professional groups, there was consistent representation among general and special educators and school administrators; in the sample; however, only 3.3% (n= 4) of respondents identified as school nurses. Given that the sample in this study was a sample of convenience, the limitations were unable to be overcome.

Another limitation of this study was that the results were obtained through a self-report survey. With self-report measures, a few limitations that may have arisen included honesty of the respondents when providing their answers; how the respondent interpreted the question that was being asked, and interpretation of the meaning of the scale points from the Likert scale on the perception items. Regardless of anonymity being assured, respondents may have answered items in a certain way to appear more positive. Additionally, questions were carefully considered for issues related to multiple interpretations; however, respondents were left to interpret questions based on their own knowledge and understanding. Therefore, given that respondents have free will to respond, it is difficult to control for these limitations. The third limitation of this study is that the measure used in the study was created for the purposes of this study. Therefore, the survey may lack internal consistency. The final limitation of the study is that there is

limited research on the topic of this study. This limitation may exist because there is limited consistency concerning the conceptualization of school refusal behavior. Furthermore, there is limited research regarding school refusal in general.

Future Directions

Future research should aim to examine the knowledge and perception of school refusal behavior among school staff, including more male participants and more diversity among roles within mental health and non-mental health professional groups. Expanding the sample of the study will allow for more generalizability of the findings. In future research, there should be an additional examination of simple, applicable intervention techniques that can be implemented easily by any school staff member. For example, strategies and suggestions should be examined; these may include having someone meet the student at the front door, allowing the student to have a modified schedule, allowing the student to have a flash pass to leave to speak with a mental health professional in the building, or allowing the student to enter or leave the building or transition between classes early/late. Furthermore, these strategies should be evaluated using a functional analysis in order to determine which strategies are more effective, based on the function of the student's school refusal behavior. Many of the techniques addressed in the current research were more therapeutic or clinical in nature, which is not always conducive to the school setting. In future research, a greater emphasis should be placed on professional development for school personnel regarding school refusal behavior. School personnel should be provided with professional development on the various factors, including risk and protective factors, and functionality of school refusal behavior in order to distinguish emotionally-based school refusal and delinquency, assessment of school refusal behavior,

and treatment of school refusal behavior, including practical strategies. Furthermore, a pre-test and post-test from these professional development sessions may be helpful in determining the knowledge and perceptions of school refusal behavior among school personnel, following training. Given the perception that parents are influential in student attendance regarding school refusal behavior, having parents complete a survey may provide additional insight into parental understanding of school refusal behavior. Additionally, research for parents should emphasize the importance of parent training on managing children with school refusal behavior. A final future implication is in determining how the student support teams in school are able to support students with school refusal behavior. Future research should explore the effects of having a multi-disciplinary team that provides professional development and support to students, families, and school staff who are affected by school refusal behavior. The research should explore how a multi-disciplinary model would influences a student's attendance, academic performance, and level of need for social/emotional support.

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Appendix A

School Personnel's Knowledge and Perception of School Refusal Behavior Survey

Introduction to the survey:

My name is Joshua Foy and I am a doctoral candidate in the School Psychology program at Philadelphia College of Osteopathic Medicine. For my dissertation, I am conducting research on school personnel's knowledge and perception of school refusal behavior for the purpose of gaining a better understand of current knowledge and perception to inform the need for professional development for school personnel. The study consists of a survey that can be accessed by clicking on the link below. Completion of this survey is voluntary and you may choose to stop at any time. The information will be used for research purposes only and no identifying information will be collected. This survey is for school personnel such as school-based administrators, school counselors, school social workers, school psychologists, teachers, nurses or pupil personnel workers who work with school-aged students. The survey should take approximately 10 minutes to complete. If you have any questions please feel free to contact me at joshuafoy@pcom.edu or 443-642-0850.You may also contact my dissertation chair, Dr. Katy Tresco at katytr@pcom.edu or 215-871-6630. If you have additional questions or concerns regarding the rights of research participants you can call the PCOM office of Research Compliance at (215) 871-6783. Your participation is appreciated.

Inclusion criteria: Please indicate "yes" or "no" to the following questions:

1. Are you at least 21 years of age?
2. Are you a United States citizen?
3. Do you speak, read, and understand English?
4. Do you work in a school setting?

Risk and Protective Factors of School Refusal Behavior

1. **Child and adolescent variables that are considered risk factors for school refusal behavior may include all of the following ***EXCEPT*:**
    a. Student's history of psychiatric disorders
    b. Poor coping strategies
    c. Not making it on the school's sports team
    d. Failing academically in school
    e. I do not know

2. **Parent and family variables that are considered to be a risk factor for school refusal behavior may include all of the following ***EXCEPT*:**
    a. Parent history of psychiatric disorders
    b. Parental disengagement in school
    c. Parent incarceration
    d. Parents education achievement

e. I do not know

3. **Which of the following school climate variables pose as a risk factor for school refusal behavior?**
    a. Implementation of a bullying prevention program
    b. A gay straight alliance club at the school
    c. School where diversity issues are addressed
    d. Harsh discipline practices
    e. I do not know

4. **Which of the following community variables pose as a protective factor for school refusal behavior?**
    a. Living in a community with limited resources
    b. Living in a community that has many mental health services available
    c. Living in a community with high police presence
    d. Living in a community with significant drug and gang activity
    e. I do not know

Four-Function Model

5. Johnny is a seventh grade student at Sample Middle School. Johnny has been the target of the school bully, Jordan. Johnny and Jordan cross path during their last period class. This gives Johnny a great deal of anxiety. Therefore, when his mom tells him to get up and get ready for school in the morning, Johnny pleads with her to let him stay home. He has even went as far as begging his mom to homeschool him. As a last resort, he calls his mom to come pick him up before his last class, feigning sick. **What function is maintaining Johnny's behavior?**
    a. Attention
    b. Escape
    c. Tangible
    d. Avoidance
    e. I do not know

6. Sarah is a first grade student who attends Survey Elementary School. Every morning when Sarah's dad wakes her up for school, she throws a big tantrum. She screams, cries, and bangs her feet and hands on the floor. It is often embarrassing for Sarah's dad when she tantrums on the way out of the door and in the car loop at school. Her dad attempts to hug her, tell her it is okay, and offer her treats if she goes to school. In the end, Sarah does not stop her tantrum, so her dad stays home with her. Once she knows they are staying home, she calms down. **What function is maintaining Sarah's behavior?**
    a. Attention
    b. Escape
    c. Tangible

d. Avoidance
e. I do not know

7. Alex is a tenth grade student at Question High School. Alex's parents leave for work before he goes to school. Alex gets up most days around 10 a.m. despite his first period class starting at 8:00 a.m. On these days, Alex goes to other friends' houses, smokes marijuana, and watches television. He makes sure he comes home in time for his parents not to suspect that he is missing school. **What function is maintaining Alex's behavior?**
    a. Attention
    b. Escape
    c. Tangible
    d. Avoidance
    e. I do not know

8. Deshawn is a fifth grade student who attends Anywhere Elementary School. Deshawn has always attended school regularly. This school year, Deshawn's school has begun implementing different elements of restorative practices, including morning meetings. The students have to sit in a circle and share their ideas, based on a question presented by the teacher, in front of all their peers. Deshawn does not like to talk in front of others. He often struggles to engage in conversation with peers. Deshawn has recently been refusing to go to school. He will not get out of bed in the morning, despite having 10 hours of sleep. He will not leave his house. When they drive past his school on the weekends, he becomes very anxious and starts to tremble. **What function is maintaining Deshawn's behavior?**
    a. Attention
    b. Escape
    c. Tangible
    d. Avoidance
    e. I do not know

Perception

9. **There is no major differences, behaviorally, in students who refuse school due to anxiety or depression and students who refuse school due to defiance.**
    a. Strongly agree, Agree, Neutral, disagree, strongly disagree

10. **There is no major differences, emotionally, in students who refuse school due to anxiety or depression and students who refuse school due to defiance.**
    a. SA, A, N, D, SD

11. **Students who refuse to attend school based on reasons related to anxiety or depression should be treated the same as students who refuses to attend**

school due to defiance or wanting to engage in other more enjoyable activities.

a. SA, A, N, D, SD

12. **Students who refuse to come to school use anxiety or depression as an excuse to stay home from school. They are actually just trying to get out of coming to school to do their work.**
    a. SA, A, N, D, SD

13. **If a student's parents would force him or her to go to school, it would improve the student's attendance, regardless of whether or not the student refuses to attend school due to anxiety/depression or defiance.**
    a. SA, A, N, D, SD

14. **Students who refuse to attend school based on reasons related to anxiety or depression ARE treated the same by administrators and other staff members as a student who refuses to attend school due to defiance or wanting to engage in other enjoyable activities.**
    a. SA, A, N, D, SD

15. **I have heard people in my school make statements or take actions that would suggest that they do not feel a student is missing school because of anxiety, but more so due to defiance.**
    a. SA, A, N, D, SD

16. **Staff in my school take the time to help determine the reason why a student is frequently absent from school.**
    a. SA, A, N, D, SD

17. **Staff in my school are supportive of students who demonstrate financial difficulties and lack necessary resources to be successful in school.**
    a. SA, A, N, D. SD

18. **Staff in my school are supportive of students who demonstrate anxiety-based school refusal behavior.**
    a. SA, A, N, D, SD

19. **I feel I have enough knowledge to work with and support students with school refusal behavior?**
    a. SA, A, N, D, SD

20. **I need more training to be able to work with and help students with school refusal behavior?**

a. SA, A, N, D, SD

Primary Role in the School Setting:

A. General Education Teacher
B. Special Education Teacher
C. School Counselor
D. Administrator
E. School Psychologist
F. School Social Worker
G. Pupil Personnel Worker
H. School Nurse
I. Other : ☐

Assessment of School Refusal Behavior

21. A comprehensive assessment of school refusal behavior would take into consideration the following domains of functioning: Check all that apply.

a. The student's mental health
b. Social development
c. Emotional development
d. The parent's mental health
e. Academic functioning
f. Cognitive functioning
g. Health/Medical factors
h. Parenting styles

22. What is one of the most important components of an assessment for school refusal behavior?

a. Record reviews
b. Cognitive testing
c. Interviews
d. Functional behavior assessment
e. I do not know

23. What is the most important reason to include a cognitive assessment when assessing school refusal behavior?

a. To ensure the refusal to attend school is not related to another factor, such as a learning disability
b. It is not important
c. Cognitive testing would help to identify the reason they are refusing to attend school
d. Cognitive testing would identify the student's strengths
e. I do not know

24. What is the rating scale that helps to determine the function of a student's school refusal behavior?

a. Behavior Assessment System for Children- Third Edition
b. Childhood Behavior Checklist

c. Beck Youth Inventories
d. School Refusal Assessment Scale-Second Edition
e. I do not know

25. A functional behavior assessment should include:

a. Interviews with the parents and students
b. Record reviews, interviews with parents, students, and teachers, behavior checklists, and observations of student, teacher, and peers across multiple settings
c. Direct observations of the student
d. Record reviews, interviews with parents and teachers, behavior checklists, and an observation of the student
e. I do not know

Treatment of School Refusal Behavior

26. What theoretical framework has the greatest effect on increasing student attendance when treating students with school refusal behavior?

a. Rational Emotive Behavior Therapy
b. Solution-Focused Therapy
c. Dialectical Behavior Therapy
d. Cognitive Behavior Therapy
e. I do not know

27. What treatment protocol has been researched to have the greatest effect on decreasing anxiety and improving school attendance of students who exhibit school refusal behavior?

a. Pharmacological treatment
b. Clinical treatment
c. Pharmacological treatment and clinical treatment combined
d. Neither
e. I do not know

Demographic Information

Age:

A. 21-25
B. 26-30
C. 31-35
D. 36-40
E. 41-50
F. 51-60
G. >60

Gender:

A. Male
B. Female

Geographic Region:

A. Northeast (CT, ME, MA, NH, RI, VT, NJ, NY, or PA)
B. Midwest (AR, IL, IN, MI, OH, OK, WI, IA, KS, MN, MO, NE, ND, SD)
C. South (AL, DE, FL, GA, KY, LA, MD, MS, NC, SC, TN, VA, DC, WV)
D. West (AZ, CO, ID, MT, NV, NM, UT, WY, AK, CA, HI, OR, WA)
E. Other (PR, VI)

Highest Level of Education:

A. Bachelors
B. Masters
C. Specialist (CAS, Ed.S.)
D. Doctorate (Ph.D., Psy.D., Ed.D)

Current Work Setting: Circle all that apply

A. Public Elementary School (Pre-K to 5th grade)
B. Public Middle School (6th to 8th grade)
C. Public High School (9th to 12th grade)
D. Private School-Elementary School
E. Private School-Middle School
F. Private School-High School
G. Nonpublic School Setting

Number of Years in School Setting:

A. 0-5
B. 6-10
C. 10-15
D. 16-20
E. 20-30
F. >30

When you went through your undergraduate or graduate training, were you provided with a course on school refusal behavior?

A. Yes, I had one or more courses devoted to school refusal behavior
B. Yes, I had some lectures devoted to school refusal behavior, but not an entire course
C. No, I have not had any lectures or courses devoted to school refusal behavior

Through continued professional development, have you received specific trainings on the topic of school refusal behavior?

A. Yes
B. No

Have you read or studied about school refusal behavior with the hopes of gaining more understanding outside your work setting?

A. Yes
B. No

How many students have you worked with that have exhibited school refusal behavior?

A. 0
B. 1-3
C. 4-10
D. >10

Thank you for participating in this survey. If you have any questions about your participation or the purpose of this study please contact Joshua Foy, joshuafoy@pcom.edu, or 443-642-0850. You may contact my faculty mentor, Dr. Katy Tresco, at Katytr@pcom.edu or 215-871-6630. If you have additional questions or concerns regarding the rights of research participants you can call the PCOM office of Research Compliance at (215) 871-6783. Your participation is appreciated.