

Available online at [www.sciencedirect.com](http://www.sciencedirect.com)**ScienceDirect**

Cognitive and Behavioral Practice xx (2015) xxx-xxx

**Cognitive and  
Behavioral  
Practice**
[www.elsevier.com/locate/cabp](http://www.elsevier.com/locate/cabp)Contains Video <sup>1</sup>

## Dialectical Behavior Therapy for School Refusal: Treatment Development and Incorporation of Web-Based Coaching

Brian C. Chu, Shireen L. Rizvi, Elaina A. Zendegui, and  
Lauren Bonavitacola, *Rutgers, The State University of New Jersey*

*Youth school refusal is a significant societal problem with broad negative long-term consequences, yet few treatments have been developed for this population. This paper reports on the development and implementation of a novel treatment program, Dialectical Behavior Therapy for School Refusal (DBT-SR), that attempts to address limitations in both existing treatment models and current delivery systems. DBT-SR employs a multimodal approach to directly address the severe emotional and behavioral dysregulation mechanisms maintaining school refusal behavior. It also incorporates a web-based coaching component to provide active, real-time skills coaching to youth and parents at the times, and in the context, of greatest need (at home, during morning hours). A pilot trial and illustrative case examples provide “proof of concept” that DBT-SR is reasonably feasible and acceptable to clients and therapists and that web-based coaching provides incremental, unique benefit. Significant development remains, as participant recruitment proved a challenge in this trial. However, results suggest that DBT-SR is a promising, novel intervention that deserves further development.*

SCHOOL refusal (SR) behavior is a multifaceted and heterogeneous problem set that affects children and adolescents (hereafter referred to as youth) across the age spectrum and is associated with serious health, educational, and legal/status outcomes (Kearney, 2008). SR behavior refers to any youth-initiated inexcusable absence and includes both truancy (illegal surreptitious absences linked to delinquency or academic problems that tend to occur without parental knowledge) and anxiety-based SR (resistance or poor attendance due to anxiety/distress that typically occurs with the knowledge of the parents; Egger, Costello, & Angold, 2003; Kearney). SR behavior can contribute to partial or whole-day school absences, tardiness, missed class time (e.g., nurse or counselor visits), or other disruptions to the youth’s routine that affects attendance (e.g., morning tantrums, sleep difficulties, somatic complaints; King, Tonge, Heyne, & Ollendick, 2000). Youth with chronic attendance problems and SR behavior are susceptible to a number of psychosocial and academic problems that predict poor long-term functioning (Kearney). Current psychological treatments have been only partially successful, and so developing more robust treatment applications to

address this multifaceted problem are warranted (Kearney; King & Bernstein, 2001; King et al., 2000).

Findings from a large community sample of 9- to 16-year-olds place 3-month prevalence rates of anxiety-based SR and truancy at 8% (Egger et al., 2003). However, the picture complicates when broader definitions are included. National data have estimated that 20% of fourth- and eighth-graders have missed 3 days of school or more in the past month and 7% have missed 5 days or more (National Center for Education Statistics, 2006). The short- and long-term effects of SR behavior are dramatic and include poor academic performance, social alienation, family conflict, and potential child maltreatment from lack of supervision (Kearney & Albano, 2007; King & Bernstein, 2001; King et al., 2000; Last & Strauss, 1990). Continued absenteeism brings legal troubles, financial distress, and increased rates of high-risk behaviors (e.g., alcohol/drug use, perilous sexual behavior), and ultimately can be associated with poor long-term occupational and social functioning (Kearney, 2008; King & Bernstein). Moreover, SR can be a costly burden to the education system in terms of professional time (guidance counselors, teachers, principals, social workers, etc.), as well as the expense of alternative schools for children who are terminated from the public school system for SR behavior.

To address these needs, cognitive behavioral interventions have been examined and received modest empirical support. One test of cognitive behavioral therapy (CBT; King et al., 1998), consisting of 4 weeks of individual CBT

<sup>1</sup> Video patients/clients are portrayed by actors.

**Keywords:** school refusal; dialectical behavior therapy; web-based coaching

1077-7229/14/© 2014 Association for Behavioral and Cognitive Therapies. Published by Elsevier Ltd.

(6 sessions) plus parent and teacher training (5 sessions), resulted in 88% of youth returning to normal attendance (90% of days), compared to 29% of youth in a no-treatment waitlist. Other trials have demonstrated more modest outcomes. Last, Hansen, and Franco (1998) compared individual CBT versus an attention placebo control, and results suggested that CBT may not be sufficient to produce change beyond education and support. Twelve weeks of CBT based on adult agoraphobia treatment resulted in 67% average attendance rates by posttreatment, and 65% of youth achieved 95% attendance, but these results were nonsignificantly different from the attention control. Notably, 27% of the participants dropped out of this study due to families seeking more treatment than was offered, refusing the offered treatment, or being terminated for excessive session cancellations. Similar results were found in a comparison of combined CBT plus tricyclic medication compared to CBT plus pill placebo (Bernstein et al., 2000). Mean school attendance was only 28% after receiving CBT and pill placebo, and only 54% of the CBT and medication condition achieved remission from SR, defined as attendance in 75% of school days. In sum, youth-based CBT, using psychoeducation, coping thoughts, graded exposures, and parent-management techniques, may be a promising intervention for many youth, but outcomes are partial and experienced only by some.

The existing CBT model may have limitations in both its treatment model and delivery system. First, in terms of treatment model, the prevailing model may insufficiently target the emotional and behavioral dysregulation mechanisms maintaining SR behavior. Clinically, youth with SR present with a high degree of somatic symptoms (e.g., sickness, panic attacks, muscle tension, stomachaches, sleep disturbances, migraines, and headaches), behavioral dysregulation (e.g., clinging, freezing, reassurance seeking, escape, oppositionality and defiance), and catastrophic thinking (e.g., “I can’t handle it,” “I can’t make it through the day,” “School’s too hard”). Such symptoms suggest significant emotional and behavioral dysregulation and poor abilities to cope with increased stress and tension. Research supports the notion that school refusers rely on nonpreferred emotion regulation strategies, such as expressive suppression, which prioritize short-term emotional relief over long-term change (Hughes, Gullone, Dudley, & Tonge, 2010). Past clinical trials have predominantly applied CBT protocols originally designed to treat the anxiety, avoidance, and unrealistic thinking patterns of anxiety disorders (Kearney, 2008). However, a treatment approach that directly targets the emotional and behavioral dysregulation processes may produce more enduring behavioral change.

Second, in terms of treatment delivery, standard treatment approaches tend to over-rely on clinical consultation

and practice that takes place at a neutral clinic setting. Yet, youth with SR behavior likely need the most help in contexts where SR behavior is most evident (i.e., at home during morning hours, in school). Further, treatment appointments are relatively short in duration (e.g., 1 to 2 hours a week) compared to the rest of the youth’s life. A common problem in all psychotherapy is that there is always a time lag that occurs between the initial event (e.g., refusal behavior 2 days prior), the subsequent therapy session, and the ability to practice any advice on a subsequent later event (e.g., when the same precipitant is present 2 days later). All of these issues point to the need to incorporate methods for addressing problems when they are occurring or about to occur in one’s natural environment.

With these limitations in mind, we developed a novel approach for SR behavior in youth: *Dialectical Behavior Therapy for School Refusal* (DBT-SR). DBT is a logical choice of treatment for SR for several reasons. First, a number of SR cases present with significant emotion regulation problems and DBT conceptualizes most problem behavior as resulting from problems of emotion dysregulation. Second, DBT skills target content areas directly relevant to youth with SR that stem from emotion dysregulation and avoidance of negative affect. Third, DBT has been modified for children and adolescent populations with success. These modifications include incorporating the family into treatment to increase the likelihood that all family members learn how to skillfully interact. Fourth, DBT emphasizes in vivo skills coaching by making the therapist available outside of session to provide distance coaching so that skills learned in treatment can generalize to one’s natural environment. DBT-SR adds a new method for conducting skills coaching: web-based coaching between the youth, parents, and the primary therapist in the morning on school days. The current paper describes the model, structure, and main strategies of DBT-SR. Then, case studies from a pilot open trial are presented to illustrate DBT-SR interventions.

### Description of DBT-SR

DBT is a psychosocial treatment originally developed to treat adults with suicidal behaviors and borderline personality disorder (Linehan, 1993a, 1993b). A core premise of DBT is that indices of behavioral dyscontrol (e.g., impulsivity, suicidal behaviors, avoidance) are usually maladaptive attempts to regulate one’s emotions. Thus, one of the primary goals in DBT is to teach individuals skills to more effectively manage their emotions and behaviors. A large body of literature now exists to support the efficacy of DBT (see Kliem, Kroger, & Kosfelder, 2010, for a review). DBT has been adapted to treat adolescents (DBT-A; Miller, Rathus, & Linehan, 2007) and this adaptation served as the foundation for DBT-SR.

متن کامل مقاله

دریافت فوری ←

**ISI**Articles

مرجع مقالات تخصصی ایران

- ✓ امکان دانلود نسخه تمام متن مقالات انگلیسی
- ✓ امکان دانلود نسخه ترجمه شده مقالات
- ✓ پذیرش سفارش ترجمه تخصصی
- ✓ امکان جستجو در آرشیو جامعی از صدها موضوع و هزاران مقاله
- ✓ امکان دانلود رایگان ۲ صفحه اول هر مقاله
- ✓ امکان پرداخت اینترنتی با کلیه کارت های عضو شتاب
- ✓ دانلود فوری مقاله پس از پرداخت آنلاین
- ✓ پشتیبانی کامل خرید با بهره مندی از سیستم هوشمند رهگیری سفارشات