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SCHOOL REFUSAL: TWO COUNSELLING INTERVENTIONS

by

Grant Richardson

B.ED., SIMON FRASER UNIVERSITY, 1982.

THESIS SUBMITTED IN PARTIAL FULFILLMENT OF  
THE REQUIREMENTS FOR THE DEGREE OF  
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## Abstract

This study reports on an investigation of two counselling interventions used with school refusers: systematic desensitization (SD) and reframing with positive connotation (RPC). Two research questions were investigated: 1) is RPC an effective intervention with school refusers? and 2) do the two treatments impact clients in different ways?

Subjects were 19 students in grades Kindergarten to nine. Of these, nine were assigned to the SD condition while 10 were in the RPC group. The groups were similar in terms of age, grade level, sex and family composition.

A between subjects design with two independent variables (SD and RPC) was used. Each treatment consisted of four counselling sessions. Efficacy of the treatments was determined with three measures: 1) the child's school attendance, 2) the Child Behavior Checklist (CBC), and 3) the Revised Children's Manifest Anxiety Scale (RCMAS). Two measures were used to assess possible differences in the impact treatments had on clients: the Causal Dimension Scale for Close Relationships (CDSCR) and the Structural Analysis of Social Behavior (SASB). Data were collected before and after counselling for all the above measures.

Among the efficacy measures significant change over time but not between the treatments was found ( $p < .05$ ) in the children's behavior (CBC). A significant interaction was observed between treatment and time on the RCMAS but

the treatments did not differ. No differences were found over time or between treatments for attendance.

The treatments were comparable for efficacy. However, they did appear to impact the subjects in different ways. SD affected the children's anxiety while RPC did not. Parents in the RPC group, but not the SD group, felt that their authority had increased and that this was accepted by their children. Parents in the SD group rated their children as becoming more hostile towards them than did the RPC parents. However, due to the limited sample size, these results cannot be generalized beyond the participants in this study. Implications of these findings for counsellors are discussed.

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## Chapter I

### Introduction

An important role of school counsellors is to help students adapt to schools. For some students their adjustment to school is problematic; they avoid attending or are unable to attend without anxiety. This is often referred to as school refusal. School refusers pose serious problems for the school system (Brulle, McIntyre, & Mills, 1985) and for parents (Hsia, 1984).

A large part of the school refusal literature consists of articles with psychoanalytic or behavioral perspectives. Both the psychoanalytic and behavioral approaches to intervention stressed working with the individual school refuser. Recently, a few articles based on a brief strategic model and a constructivist epistemology have appeared in the school refusal literature (Carrow, 1989; Hawkes, 1981; Hsia, 1984). However, questions remain with respect to the relative efficacy and the differential applicability of individually based versus family system based approaches.

Behavioral interventions have been researched widely with school refusers (Blagg, 1987). These behavioral interventions derive from a reductionist and realist theoretical perspective which holds that reality exists independently from the perceiver; the flow of information is from the outside world inward (Dowd & Pace, 1989). The

focus of behavioral interventions is on breaking up associative ties which have come about as a result of the passive acquisition of contingency relationships. Respondent and operant contingency management plans are well known and extensively researched.

In contrast to behavioral interventions, strategic interventions have not been researched widely with school refusers (Blagg, 1987). The strategic approach is based on constructivist theory which holds that there is an interrelationship obtaining between mental schema and some independent set of circumstances; the individual perceiver is thought to be an active participant who screens and processes information and has mental constructions of reality which mediate experience (Dowd, et al., 1989). A strategic approach stresses a systems viewpoint: human beings organize their perceptions of the world in terms of groups or systems and in order to understand a selected bit of behavior it needs to be considered in terms of its function within the system of which it is a part (Fisch, Weakland & Segal, 1988; Watzlawick, Weakland & Fisch, 1974). The thrust of strategic treatment interventions is to alter the mental schema. Strategic interventions have been applied to the problem of school refusal (Carrow, 1989; Hawkes, 1981; Hsia, 1984) but have not been as extensively researched as behavioral interventions.

Systematic desensitization (SD) is a behavioral intervention based on the assumption that fears and

anxieties are the result of associative ties between the environment and the individual. The thrust of SD is to produce in the individual a different and incompatible response to one previously acquired through conditioning by replacing fear or anxiety with relaxation (or some other response incompatible with the fear or anxiety). SD has proved to be an efficacious intervention with school refusers (Blagg, 1987; Chapel, 1967; Croghan, 1981; Garvey & Hegrenes, 1966; Lazarus, 1960; Lazarus, Davison & Polefka, 1965; Miller, 1972; Montenegro, 1968; Patterson, 1965; Tahmisian & McReynolds, 1971). However, most of the studies which have used SD were single case studies or lacked control groups (Blagg, 1987; Trueman, 1984a). Even taking into account these criticisms, the number of studies in which SD has been used with success as either the exclusive treatment method or in combination with other methods suggests that it is an effective intervention with school refusers.

In contrast to SD, reframing with positive connotation (RPC) is an intervention based on the assumption that problems, including fears and anxieties, result from an interaction between an individual's patterns of thinking and experience. For example, someone whose pattern is to expect hostility will be more likely to interpret experiences as hostile: their experiences will support their beliefs and their beliefs will color their experiences. RPC involves shifting the meaning attached to

a problem or changing the thinking of the client by attributing a positive meaning to the behavior of someone or something connected in an important way to the problem.

RPC has no empirical support in the school refusal literature. Research focusing exclusively on RPC with school refusers is non-existent. Some authors (Bowman & Goldberg, 1983; Carrow, 1989; Hawkes, 1981; Hsia, 1984; Kolko, Aylon & Torrence, 1987), however, have reported using RPC in conjunction with other techniques with school refusers. Since RPC has been only one of several techniques employed in these studies, it is unclear to what extent it may be efficacious in dealing with school refusers.

Although not proven empirically as a technique for use with school refusers, RPC has been found to be effective with other, similar, problems. It has often been used as the initial step in multi-step interventions: a reframe often precedes and is part of techniques such as symptom prescription (Fisch, et al., 1982). Indeed, it has been found by some to be the most effective and perhaps, the only necessary ingredient for producing change in techniques that use it as one step in a series of steps (Hill, 1987; Kraft, Claiborn & Dowd, 1985; L'Abate, 1984; Shohan-Saloman & Rosenthal, 1987). RPC has been used with several different problem areas, such as insomnia, depression and anxiety (Hill, 1987). Several authors have viewed anxiety as the main characteristic of school

refusers (Bernstein & Garfinkel, 1986; Croghan, 1981; Frick, 1964; Kelly, 1973). Others emphasized depression (Agras, 1959; Kolvin, Berney & Bhate, 1984; Tisher, 1983). Since anxiety and depression are often cited as components of the school refusal problem and RPC has had success with both, it is likely that the technique could be utilized with school refusers.

The assumption underlying RPC is that the symptom (school avoidance), though painful, may also serve to protect the family from impending changes that threaten the system. Such threats produce anxiety. Focus on the positive aspects of the child's behavior shifts the thinking of family members to the underlying tension in the system and provides the child with an opportunity to return to the classroom. The problem is seen as residing in the thinking of family members or perhaps in the thinking of school teachers. Consequently, the focus of the intervention is on how the mental schemas maintain problematic behavior.

A recent evaluation of family therapy research (Hazelrigg, Cooper & Borduin, 1987) concluded that there is a need to focus more on the specific effects of specific interventions with particular types of counselling clients. Not enough is known about whether the favorable effects obtained in some studies were the result of an interaction between the technique and the type of population or about the differential effectiveness of specific interventions.



Hazelrigg et al. (1987) suggested that "research should concentrate on comparative outcome studies" (p. 428). Trueman (1984a) and Blagg (1987) have both commented that the school refusal literature was characterized by a lack of well controlled and of comparative studies. Both authors also note a blurring of treatment techniques which make judging differential effectiveness impossible. Thus, comparing SD with RPC would avoid the blurring of techniques found in multiple technique interventions and help in learning more about the differential effectiveness of the interventions-- particularly the less researched RPC method.

#### Research Questions/Hypotheses

This study tried to address two research questions. First, would RPC be an effective intervention for use with school refusers? Since SD has an established record with school refusal, it is used as a comparison group to determine if the empirically unsupported RPC can equal or surpass the success of SD. Efficacy will be determined in terms of school attendance, the children's anxiety levels and children's behavior problems.

There are some hypotheses associated with the first research question. For school attendance, it is expected that both groups will produce improvements from pretest to posttest. A reduction in the amount of children's behavior problems is also expected for both treatment conditions since indicators of anxiety, depression and other problems

associated with school refusal will be accessed by the instrument used. Anxiety levels are not expected to change in the same way for both treatment groups: a greater reduction in anxiety is expected for the SD group since reducing anxiety is the major goal of the treatment.

The second research question was: Will the two treatments produce changes in how the parents thought about their children's school refusal? These changes were measured in terms of parental attributions about the cause of the school refusal and in terms of changes in parental perceptions of themselves, of their children and of their relationship to their children.

A number of hypotheses also arise out of the second research question. Some hypotheses concerned the parents' causal attributions about the school refusal. The SD condition was expected to produce four changes in attributions: 1) an increased emphasis on circumstances or environmental factors, 2) an increased sense of control over the problem 3) an increased sense that the cause of the school refusal was something specific rather than global and 4) a change towards believing that the child was the cause of the problem. The RPC condition was expected to produce five shifts in parents' causal attributions: 1) parents were predicted to be able to take more responsibility for the problem rather than blaming their child, 2) parents would take more responsibility rather than blaming circumstances for causing the problem, 3) the

school refusal would be seen as less intentionally caused, 4) the parent's attitude towards the problem would become more positive and 5) the problem would be perceived to be less stable after counselling.

Possible changes in the parent-child relationship towards being either more friendly or more hostile and towards giving more autonomy or taking more control also arise out of the second research question. The parents in the SD group were expected to increase their sense of control over their children since they would be given a method for managing their children's school attendance problem. As a result of this improved sense of control, the SD parents were expected to have a more positive feeling about themselves. The children in the RPC group were expected to be perceived as more friendly towards their parents because their behavior would have been reframed in a positive way. It was thought that the improved feeling about the children would lead to the RPC parents feeling better about themselves. Also, the change in perception concerning the children's behavior was expected to produce a situation where the parents would find it easier to accept parental control and the children would find it easier to accept parents who were more controlling.

## Chapter II

### Literature Review

The research literature on school refusal has often been inconclusive and plagued with definitional problems (Atkinson, Quarrington & Cyr 1985; Blagg, 1987; Frick, 1964; Kelly, 1973; Ollendick & Mayer 1984; Shapiro & Jegede 1973; Trueman 1984a, 1984b). Ideas about etiology and treatment are dependent on the theoretical perspective of the researcher and have been dominated by psychoanalytic and behavioral approaches. More recently, however, methods based on constructivist theory have begun to appear in the literature. A review focusing on definitional problems, important theoretical perspectives and intervention strategies is presented. Particular attention is paid to systematic desensitization (SD) and to the strategic technique of reframing with positive connotation (RPC) as a background for the techniques used in this study.

#### What Is School Refusal?

In the literature school refusal was first described by Broadwin (1932) and was defined as a special type of truancy. Truancy was defined as absence without acceptable excuse. The new subset of truants that Broadwin described were absent due to fears and anxieties. These anxious truants were labeled "school phobic" by Johnson, Falstein, Szurek and Svendsen (1941). Referring to Johnson et al. (1941) and other early writers Blagg (1987) said that

they "did not regard the condition as a specific entity but rather a loose description of any school attendance problem based on emotional disturbance with phobic, hysterical and obsessional tendencies often overlapping" (p. 6). Thus, school refusal, as it was later called by some authors, was perceived to be a heterogeneous phenomenon.

Researchers have often failed to provide explicit behavioral criteria for identifying school refusers or have not adhered to a consistent definition of school refusal (Blagg, 1985; Trueman, 1984b). To address this situation, Berg, Nichols and Pritchard (1969) provided an operational definition of school refusal consisting of four criteria: 1) severe difficulty in attending school, 2) severe emotional upset, 3) staying at home with the knowledge of the parents and 4) absence of anti-social disorders such as stealing, lying, destructiveness and so on. In this definition, truants are thought to be less emotionally upset than refusers, to spend their absent time away from home and to have higher rates of delinquency and other "acting out" behaviors. However, the definition does not specify how severe the attendance or emotional difficulty needs to be or how often a delinquency needs to have occurred or if a child needs to be exclusively in the home or away from home to be described as a refuser or a truant.

Berg, Casswell, Goodwin, Hullin, McGuire and Tagg (1985) classified four groups of attendance problems using the Berg et al. (1969) definition: 1) school refusal, 2)

truancy, 3) both truancy and refusal and 4) poor attenders who were neither refusers nor truants. Thus, the Berg et al. (1969) definition can distinguish between truants and refusers but only if some non-attenders are left out or classified in another way. It seems that truants and refusers can be clearly distinguished from each other only in a broad way: the anti-social behavior of refusers is confined to school avoidance while truants take their difficulties into the community at large.

Both truants and refusers are generally perceived to have something wrong with them; an underlying cause for the problem is sought. For Pratt (1983) the initial premise with this position is "that such behavior is irrational, and is caused by individual failings or deficiencies" (p. 350). Brown (1983) thought that more attention should be paid to how the truants perceive themselves and their situations rather than merely diagnosing them and applying a label. School attendance requires children to become members of a more complex system and adapting to this system may cause problems for some. From the child's point of view, it may make sense to withdraw to the security of the family when faced with a new school, bullying peers or a frightening teacher: within the child's frame of reference the refusal may be quite rational rather than indicative of individual deficiencies.

Shapiro et al. (1973) argued in favor of seeing truancy and refusal as opposite ends of a continuum with

less clear cut cases falling in between. They pointed out that a child may turn to peers outside the home or to their mother depending on the support the child feels can be mustered from either place and so, "the truant's as well as the school phobic's pattern must be evaluated in context" (p. 198). Some members of either group could behave like their opposite if circumstances were to allow it. Thus, the distinction between them does not necessarily reflect differences in individual traits such as fear and anxiety.

Most children experience fears or anxieties. Some fears, such as a fear of the dark, are age appropriate (Johnson, 1979; Ollendick et al., 1984). Ollendick et al. (1984) suggest that age appropriate fears become problematic when they are excessive, unrealistic and persistent. It is normal to experience some anxiety about beginning to attend school, or about moving to a new school, or switching from elementary to secondary school. However, if these fears are not outgrown or if they prevent the child from doing what is normally expected of children of their age then they become problematic.

A multiple problem picture was supported by Last, Strauss and Francis (1987) who found a variety of anxiety disorders, with no clear-cut pattern of overlap. In fact, several writers have described school refusal as a heterogeneous phenomenon (Atkinson, et al. 1985; Frick, 1964; Grannel de Aldaz, Feldman, Viva, & Gelfand 1987; Kolvin et al. 1984; Waldron, Shrier, Stone & Tobin, 1975).

Bernstein et al. (1986) said that, "children with depressive disorders and children with anxiety disorders describe many of the same symptoms" (p. 235). Last et al. (1987) while examining comorbidity in childhood anxiety disorders did not find a clear cut pattern with school refusers but saw overlap with other disorders. It seems clear that the school refusal population cannot be described in terms of a single symptom.

Refusers are a heterogeneous group not always easily distinguishable from truants. Certainly, diagnostic categories such as anxiety or depression do not distinguish them. Perhaps, we have not progressed much from Broadwin's time when a truant was defined as someone absent from school without an excuse acceptable to the school authorities and what we now refer to as school refusal was considered a subgroup of truants characterized by anxious withdrawal. Thus, a researcher has some latitude in defining school refusal since it has not been established as a clear entity.

The definition used in this study is: The child has directly refused to attend school or has indirectly refused by being absent without suitable excuse (such as illness) to the point where school personnel and parents are expressing concern or the child is attending only with great difficulty (parents and school personnel are reporting that the child is upset and/or reluctant to attend).



## Characteristics of School Refusers

Incidence. Kennedy's (1965) often cited figure of 17 per 1000 has contributed to the confusion about incidence since it was not specified how the figure was arrived at. But it is probable, since Kennedy worked in a clinic, that the figure is for a clinical population which makes it unreliable as an estimate of general incidence. Smith (1970) gave a figure of 3.8% of non-brain-injured children referred to a clinical setting in England. In a quite large scale study Granell de Aldaz et al. (1987) found .4% of the general school population to be refusers when it was required that several observers must agree that the reason for non-attendance was based upon extreme fear. A figure of .4% was also cited by Ollendick et al. (1984) but without specification of the criteria used to decide who was a refuser. Granell de Aldaz's figure rose to 5.4% when it was required that the child only have a high rate on non-attendance. A definitive figure is unlikely unless there is agreement concerning the definition of the population being studied.

Somatic Complaints. Kelly (1973) and Timberlake (1984) report that somatic complaints are invariably present in school refusers. Nausea, headache, abdominal pain, sore throat and fevers are common complaints among school refusers (King & Ollendick, 1989; Brulle et al., 1985). Fear of fainting, dizziness, vomiting and diarrhea are added to the list by O'Brian (1982). Church and Edwards

(1984) found that some felt they had odd shaped bodies, were too fat or too small. Berg et al. (1969) found somatic complaints to be a prominent feature in 16 of 29 children studied.

Sex. Trueman (1984b) noted that some studies have reported a higher proportion of girls to boys or of boys to girls. However, tallies of cases in the literature by Leventhal and Sills (1964) and by Frick (1964) show equal numbers of boys and girls. Davidson (1961), Kennedy (1965), Berg et al. (1969), Smith (1970) and Flakierska, Lindstrom & Gillberg (1988) all report about equal numbers of boys and girls in the clinical populations that they studied.

Intelligence. Frick in his 1964 review reported that, "in all studies these phobic children tend to be average or above in intelligence" (p.363). Leventhal et al. (1964) and Smith (1970) concurred. Friesen (1985) claimed that refusers were more capable students than truants. However, Church et al. (1984) found that, "the majority were found, on testing, to have mild or moderate learning difficulties" (p.28); this was supported by Granell de Aldaz et al. (1987) also with a non-clinical population. O'Brian (1982) argued that many students with learning disabilities may become discouraged and ultimately become refusers. Tisher (1983), working with a non-clinical sample, found school refusers to be of lower than average intelligence. Lower intelligence scores seem to be present in the non-clinical

studies. It may be that those who seek help at clinics are in a higher socio-economic class than those found in the general population which could influence these results. Again, operational definitions are often lacking or they are inconsistent from study to study.

### Etiology and Treatment Approaches

The major theoretical approaches to school refusal have been psychoanalytic and behavioral. More recently, research based on a strategic approach has begun to appear. The psychoanalytic, behavioral and strategic theoretical positions are reviewed below beginning with a discussion of etiology followed by a discussion of treatment methods. The sections on the behavioral and strategic interventions are divided in two parts: the first part gives a general description of each theory's approach to intervention and the second part is devoted to systematic desensitization and to reframing with positive connotation.

### Psychoanalytic View of Etiology

Johnson et al. (1941) found the common factors in the initiation of school phobia to be "an acute anxiety in the child ... an increase of anxiety in the mother...poorly resolved early dependency relationship of these children to their mothers" (p. 703). Along with this "the mother must be suffering from some new threat to her security-- marital unhappiness, economic deprivation, or demands that she resents" (p. 708). Both mother and child regress to an

earlier stage where they had found mutual satisfaction. These findings, as we shall see, were echoed in much of the literature over the next 20 or 30 years.

From the psychoanalytic perspective, the "basic fear is not of attending school, but of leaving mother or, less commonly father" (Eisenberg, 1958, p. 713). The mothers were described as anxious and ambivalent and had poor relationships with their own mothers. Waldfogel et al. (1959) also found the "dynamic origin in the hostile dependent relationship between mother and child" (p. 166). In their review of 26 cases they found "an emotional crisis reactivates unresolved conflicts that underlie the personality disturbance" (p. 167). Thus, mothers were seen as the source of the problem.

Anxiety, especially separation anxiety, has often been mentioned as a characteristic of school refusers. Ollendick et al. (1984) in a study of 37 school refusers found various types of anxiety including separation anxiety, anxiety about specific aspects of the school and anticipatory anxiety. Bernstein and Garfinkel (1986) found 62% of their 26 cases to be anxious and in a 1988 study found higher rates of anxiety in the immediate family of school refusers. According to Last et al. (1987) most clinicians and researchers think that anxiety about attending school can be either separation anxiety or fear about some aspect of the school. Last et al. (1987) found overlap between the two sources of anxiety but also a good

deal of difference. Thus, separation anxiety is not necessary for school refusal to occur but it is often present in school refusers.

Closely related to the issue of separation anxiety is the issue of dependency. Frick (1964) noted in his review that mothers of school refusers had unresolved dependency relationships with their own mothers. Timberlake (1984) in her study found a mother-child tie which was overprotective and strongly dependent. Bowlby (1973), without saying how this was determined, suggested that relations "between child and parents are close, sometimes to the point of suffocation" (p.300). Granell de Aldaz et al. (1987), who used standardized paper and pencil measures of fear and behavior problems in children, found refusers to be socially ineffectual as well as dependent in comparison to a non-refusing comparison group. The children themselves, in Ticher's (1983) study, saw themselves "as overprotected and overindulged by their mothers and fathers" (139). Thus, even though there was a widespread tendency to find dependency in school refusal populations, there was still considerable variation among refusers.

Waldron et al. (1975) found separation anxiety and dependency among school refusers in some cases but not in others. They compared 35 school refusers with 35 children diagnosed as having other neurotic problems. About 75% of the school refusers, on researcher developed paper and pencil measures, showed separation anxiety and excessive

dependency. But claims that the parents of school refusers have unresolved dependency and hostility issues with their own parents, that mothers suffer from self-doubt and depression, and that the mothers were ambivalent and hostile to their children was not supported.

Since Agras' 1959 article, depression has also been frequently found among school refusers. Davidson (1961) found 23 out of 30 to be depressed (as well as a high amount of deaths or threatened deaths in the families of refusers); Smith (1970) found 8 of 63 cases to be depressed; Waldron et al. (1975) found 56% to be depressed. Tisher (1983), using self-report methods for assessing children's depression found significantly more depression in her school refusal group (40 cases) than in her nonrefusal group (37 cases). Kolvin et al. (1984) found 45% with significant depression and 83% with dysphoric mood in their study involving 51 cases. Bernstein et al. (1986) found 69% of their 26 subjects to be depressed and in their 1988 study found a high rate of depression in the immediate family of school refusers. A variant of the psychoanalytic position is the psychodynamic or self-concept position. Blagg (1987) commented that, "many of the descriptive findings associated with school phobia do not seem to support an explanation based solely on separation anxiety" (p. 29). Several researchers (Frick, 1964; Leventhal & Sills, 1964; Rubenstein & Hastings, 1980) have noted that some children attend school for several

years before an episode of school refusal happens which raises the issue of why it did not occur at an earlier, more developmentally appropriate age. Also, separation anxiety is not always manifested in other areas of life apart from school: some of these children do not have a fear of going out to other places without their mothers. Leventhal et al. (1964), Radin (1967), and Rubenstein et al. (1980) use such arguments to criticize the more traditional psychoanalytic position. They also argue that school refusers over-value themselves or at least, have an unrealistic self-image. Radin (1967) claimed that the school refuser's ability to distinguish ego from ego-ideal is blurred by overly permissive, submissive and indulgent parents. These are children who believe in their own omnipotence. Those who favor this view do not stress precipitating events but rather suggest that the child is confronted at school by tasks that are mis-evaluated and cause anxiety because they force him/her to focus on his/her realistic limitations.

There is some empirical support for the psychodynamic view. A comparison of 57 refusers with 578 non-refusers by Granell de Aldaz et al. (1987) using paper and pencil measures of anxiety and behavior problems in children found that 21% said they had a fear of separation from parents and that those who acknowledged this tended to be younger with fear of separation decreasing with age. They also found that 53% were given extra attention and privileges

when at home which could be construed as support for the notion that parents are indulgent. Cooper (1984), in a comparison study of adolescent school refusers and truants found that for the refusers, "prestige is important... and this may be reflected in the tendency towards self-consciousness and their concern with what others are thinking of them" (p. 256): they have an expectation of feeling important and of having their importance recognized by others. Cooper says that they believe that they can manipulate both parents and teachers but become disappointed in their attempts with teachers.

Friesen (1985) states that refusers, "in their need to be inconspicuous and unthreatened, seem to disappear even while present" (p. 19). Tisher's (1983) research revealed them to be "more introverted, neurotic, reserved, submissive, guilt-prone, shy, sober, and internally restrained" (p. 139). Passivity and inhibition were found to a greater degree with refusers than truants in Hersov's (1960) study. Church et al. (1984) reported that 61% of their school based sample were introverted.

In summary, the findings of psychodynamic researchers are often based on single case studies with judgements about the causes of the refusal being made by clinicians based on their clinical experience and on their theoretical orientation rather than on standardized measures. In studies where standardized measures of anxiety were employed less separation anxiety was found than studies



which depended on clinical judgements. Also, the theory that anxieties resulting from family relations, mostly mother-child relations, are displaced onto to the school situation (Frick, 1964) depends on the existence of unconscious conflicts within the child. The psychodynamic argument is that whether or not there is evidence of separation anxiety school refusal is an attachment-separation problem-- even when there appears to be something in the school that the child fears. Since the underlying cause is unobservable, it is not surprising that there has been a lack of clearly specified behavioral criteria for diagnosing school refusal in the psychoanalytic literature. Children tend to be viewed as products of unhealthy families rather than as persons with the capacity to interact with their families and with school environments.

#### Psychoanalytic Interventions

According to Blagg (1987) "the earliest psychodynamic studies favored 'insight' before confrontation of the feared situations... [however] a number of later studies favored immediate, even forced, return to school" (p. 59). Thus, a contentious issue from the earliest research has been when to return the child to school and how much pressure to put on to gain this return (Blagg, 1987; Frick, 1964; Kelly, 1973). Rodriguez, Rodriguez and Eisenberg (1959) cite three benefits to an early return: 1) it puts the focus on the separation issue, 2) it emphasizes the

health of the child and 3) it puts the child back into a growth promoting environment. This is a widely held view: a "majority of dynamically oriented therapists have regarded an early return to school as fundamentally important" (Blagg, 1987, p. 37).

Both the self-concept group and the more traditional psychoanalysts "stress the role of analysis and insight and the building-up of ego strength and family equilibrium" (Kelly, 1973, p. 36) as basic goals of treatment. Frequently, as Kelly has observed, therapy is directed toward insight for "quick symptom relief and extended therapy is used to resolve the underlying neurosis" (p. 37). Johnson (1941) sought to relieve guilt and tension by aiming for a positive dependent transference. Davidson (1961) who emphasized hostility in the mother-child relationship wanted her clients "to see the irrationality and archaic nature of these views, and accept reality standards" (p. 284). This was done by encouraging the expression of aggression in the sessions.

The psychoanalytic view that there is an underlying cause to be found in family dynamics which needs to be brought into consciousness tends to lead to lengthy treatments. And since success in psychoanalytic studies was most often measured by a return to and ability to stay in school, the evidence that this time consuming therapy has been worth the considerable effort is lacking. Anecdotal accounts of changes beyond being able to attend

school do not represent proof that the changes actually occurred or if they did occur that there might not be some other theoretical explanation for their occurrence. Comparative studies involving a number of cases are rare. Objective measures of variables such as the mother-child relationship have seldom been employed.

#### Behavioral View of Etiology

Garvey and Hegreves (1966), like the psychoanalysts, thought the child feared the loss of the mother but only as a result of comments about leaving made by the mother which condition the child to fear school. Staying home has reinforcing properties for the child and perhaps, for the mother. Thus the child is negatively reinforced when he/she avoids the stimulus of a fear-provoking school and positively reinforced with maternal attention when he/she says home (Brulle et al., 1985). The mother can be negatively reinforced as well by avoiding being home alone and positively reinforced by the child's presence. In addition, an aversive event may be needed for school refusal to develop (Trueman, 1984b). Thus, behavioral explanations of school refusal emphasize environmental factors.

The operant conditioning view focuses on consequences, such as parents supporting negative behavior (Harris, 1980). Harris also discussed the respondent view of the situation which focuses on emotional reactions such as

separation from the mother functioning as an eliciting stimulus for an anxiety reaction.

Blagg (1987) discussed the two-stage theory of fear and avoidance: fear could motivate behavior and not be merely a conditioned reaction to stimuli. He thinks this theory is in doubt, however, because avoidance responses are resistant to extinction, often persisting long after fear has stopped. It is often difficult to specify relevant conditioned stimuli.

Circumstances are emphasized with the behavioral approach. The school is more likely to be given a role in the development of the problem than would be given by the psychoanalytic approach. The problem may originate in the circumstances facing the individual and the individual may interact with those circumstances and thus modify them. However, how the individual thinks about the problem or otherwise processes it is not taken into account: the child is thought of as a locus for receiving and responding to stimuli rather than as an active constructor of or interacter with reality.

### Behavioral Interventions

#### A. A General Outline of Interventions

Despite the large theoretical differences between the psychoanalytic and behavioral approaches they both "emphasize early return to school as the primary goal of treatment" (Ollendick et al., 1984, p. 386). This preference for rapid return, while not universally accepted

among behaviorists, is based on the idea that it minimizes the chances of secondary gain occurring. A simple fear reaction to an aversive stimulus, say a class bully, can be worsened if the child receives reinforcing attention at home and then builds up anticipatory anxiety about returning to school (King et al., 1989). Thus, the earlier the return the less time there is for learning that home is a permissible alternative to school.

Interventions based on the operant model seek to increase the reinforcement value of the school through interceding in peer relations, with the teacher or some other aspect of the school situation (King et al., 1989). A simultaneous effort to decrease the reinforcement value of staying home through removing or decreasing things such as t.v. watching time or getting extra attention from parents during school hours is made. A shaping procedure which rewards successive approximations to the goal of returning to school has often been used (Ayllon, Smith & Rogers, 1970; Trueman, 1984a). Thus, though the goal may be a quick return, the return is often accomplished in a graduated manner with operant procedures.

Kennedy (1965) demonstrated that successful treatment of school refusal could be accomplished with a brief, rapid return through the technique of flooding. He reported on 50 Type I cases (younger children with an acute onset of the problem) and listed the components of the procedure as, "good professional public relations, avoidance of emphasis

on somatic complaints, forced school attendance, structured interview with parents, brief interview with child, and follow-up" (p. 181). He advocated the use of force if necessary to return the child to school but he recommended seeing the child only briefly and then telling stories which stress the advantages of going on in the face of adversity. Although Kennedy's intervention plan claimed 100% success, his success may be due to his influence on family dynamics (Blagg, 1987). Also, telling stories may have created a frame of reference for the child which may have been sufficient to cause the changes reported.

Blagg (1987) also had an intervention plan which consisted of several different strategies. First, assurances must be obtained that there are no medical problems and the child's school placement is appropriate. A thorough examination of home factors and precipitating factors in the school is made. Then, desensitization of the worries of the child and his parents is undertaken. Emotive imagery is used to relate incidents in which others have successfully faced fear and danger. To avoid the parent questioning the child, daily telephone contact between school and parents is encouraged. At the next stage contingency management techniques stressing positive reinforcement and the minimization of secondary gains are used. Finally, a flooding technique is used in which the therapist insists upon an immediate return to school. Follow-up involves a careful monitoring of absences through

maintaining contact between parents and the school. Again, it is difficult to tell if one strategy could be effective on its own or if it is the combination of strategies which produce the reported successes.

#### B. Systematic Desensitization (SD)

SD usually involves teaching relaxation and a gradual exposure to hierarchically arranged anxiety provoking situations (Emmelkamp, 1982; Morris & Kratochwill, 1987; Wolpe, 1958). The anxiety provoking situations may be presented either imaginally or in vivo. It is important that the hierarchy represent actual situations facing the client and that the client goes through the hierarchy starting at the least anxiety producing item and proceeding to the most anxiety producing. The basic assumption is that a fear or anxiety response cannot exist simultaneously with a relaxed state. Wolpe (1958) referred to this process of relaxation inhibiting anxiety as reciprocal inhibition.

The first case in the school refusal literature using SD was reported by Lazarus (1960). A nine year old girl was desensitized using traditional methods for separation from the mother. This was done in 5 sessions over 10 days. Chapel (1967) used SD with an 11 year old boy with initial success. But the boy had a relapse the next year and SD was continued along with unspecified additional treatments for the remainder of the school year. Croghan (1981) was successful with a 17 year old boy who had been a school

refuser for 5 years. But the major precipitating event in this case was an altercation at school and the boy's refusal to fight was reframed by the therapist as a sensible way to behave. Thus, the reframe rather than SD may have been responsible for the change.

Several articles have reported starting with imaginal SD and progressing to practicing the relaxation in the presence of the anxiety producing stimuli (Lazarus, Davison & Polefka, 1965; Miller, 1972; Patterson, 1965; Tahmisian, et al. 1971). Lazarus et al. (1965) treated a nine year old boy with traditional SD methods but failed to effect a change. Persisting, they tried SD in a "real life" situation and a reinforcement schedule where the mother's aid was enlisted. Better success was achieved when the actual anxiety producing situations were used along with operant techniques. Patterson (1965) used doll play to simulate the anxiety producing experience and later used in vivo SD and food rewards to effect separation from the parents with a 7 year old boy. Tahmisian et al. (1971), after failure of traditional imaginal SD, used an in vivo SD successfully but confounded the treatment with a contingency management program.

Garvey and Hegrenes (1966) successfully interceded with a 10 year old boy using in vivo SD procedures. They cited the establishment of a positive relationship and verbal praise from the therapists as helping to inhibit anxiety. Since relationship factors or verbal praise may



have helped to produce the positive result, it is difficult to evaluate the role of SD in this case.

SD is a technique with proven effectiveness. But it may be a highly effective placebo procedure (Emmelkamp, 1982) or a result of the client's expectancy for change (Kazdin & Wilcoxon, 1976). Kazdin et al. (1976) concluded that the overwhelming majority of studies have "failed to rule out differential expectancies for success on the part of the clients" (p. 753). Emmelkamp (1982) saw desensitization as a viable technique but pointed out that we do not know if its successes should be attributed to the treatment or an expectancy for success created by those engaged in research.

Hatzenbuehler and Schroeder (1978) reviewed SD in terms of passive association (imaginal) and active participation (exposure to graduated external stimuli). They stated that the effectiveness of imaginal desensitization techniques "with children is not well supported by research" (p. 834). A variation of the passive version involves pairing the usual relaxation response with an exteroceptive stimuli (this would include in vivo methods as well as the presentations of other non-imaginal stimuli). The imaginal variant could be suitable for children who are capable of relaxation responses but who have trouble manipulating imagery.

It seems that SD "is most frequently applied to the modification of avoidance behavior" (Hatzenbuehler et al.,

1978, p. 841) which would make it suitable for many school refusers. They added that the tendency is for in vivo techniques to work better with children, especially younger children, than imaginal ones. This conclusion was supported by a study of children with a fear of water conducted by Ultee, Griffioen and Schellekens (1982) and by Emmelkamp (1982). Passive techniques would be best used with those who have severe avoidance behavior. However, a major advantage in using SD is its amenability to a variety of procedural adjustments which do not alter the basic structure. This adaptability would be especially useful with school refusal which afflicts children of various ages and is characterized by heterogeneity.

However, SD also has limitations. Deffenbacher and Suinn (1988) concluded their review by noting that desensitization is most useful "for conditions of high emotional-physiological arousal that are triggered by clear environmental stimuli" (p. 26). They also commented that desensitization seemed appropriate in cases where the client has "a passive, therapist control set or very low self-efficacy" (p. 27).

#### Strategic View of Etiology

A shift during the 1960's and 70's from a focus on the child as the problem to a focus on relationships within the family was noted by Hsia (1984). Bolman (1970) and Shapiro et al. (1973), while continuing to think in terms of intrapsychic mechanisms, suggested a broadening of the

conception of school refusal to include individuals, families and the community. This was a step towards seeing the problem in terms of relationships where the focus of attention is on the function of the problem and on the perception of the problem by individuals.

Hawkes (1981) concentrated his analysis on symptomatic behavior within the family which was "viewed as having a stabilizing function for the system as a whole" (p.56). Thus, the problem helps to maintain balance and stability. For example, a mother may feel lonely when her youngest child goes to school. The accustomed balance of their lives has been disrupted. The child, sensing this, may return the family to its former sense of order by staying at home with the mother. These factors are viewed not as causes but ways that dysfunctional behavior can be maintained. Hawkes (1981) believes that refusers often over-estimate their own power; but he also sees this over-estimating in terms of how the family supports this belief. The family makes a contribution to how the child constructs his/her view of him/herself. Nevertheless, it is important that the problem is not found within the child or his mother but in dysfunctional patterns in the family which have a positive function in maintaining stability within the family. Rather than saying a mother has been overprotective the counsellor would look for ways that the child lets the mother know he/she is in need of protection.

It is a dance mother and child do together which has information flowing in two directions.

The interaction of the family system with the school system was discussed by Wetchler (1986) as well. He argued that when children begin to attend school they become members of "a second system, the school, and a third, more complex system in which the other two are separately nested, the family/school interactional system" (p.226). Thus, school refusal is conceptualized as a developmental problem: the child is having difficulty making the transition from the family system to the school system. The result is often disagreement about how to handle the child's problematic behavior. Similarly, Will and Baird (1983) argued that conflict arises between professional systems and the families of school refusers.

Whether the focus was the relationship between family members or between families and schools it was the pattern of relationship which is examined. Attention was given to how a problem is maintained rather than what caused it (Watzlawick et al., 1974; Fisch et al., 1988). The counsellor needed to know such things as who benefits from keeping things the way they are and how they benefit. Often it is the attempted solutions of the clients that are maintaining the problem. These attempted solutions result in repetitious, cyclic patterns of behavior rather than a solution.

## Strategic Interventions

### A. A General Outline of Interventions

Paying attention to interactional patterns often means involving family members or school personnel in counselling. Hsia (1984) recommended working with the family and obtaining cooperation from school personnel. Wetchler (1986) recommended approaching the problem from a macrosystemic view: the family and school are interacting systems and the focus of treatment is on interceding with these larger systems. A constructivist systems approach does not specify which individuals would be involved in counselling but does put the emphasis on the relationship between individuals or larger systems and individuals. Amatea (1989) even suggested that the intervention may be sometimes aimed at changing the problem-maintaining responses of the school staff.

Forced return to school is not recommended by those favoring a systems approach. Hsia (1984), however, recommended establishing a proper parent-child hierarchy by taking steps to put parents in charge. The parent would not be asked to demand an immediate return but would be encouraged to take control in other ways which may result in the parent ultimately being more demanding concerning school attendance. Solutions are favored which allow the clients to respond to what the counsellor has said in their own way rather than assuming that the counsellor knows the "right" way for the clients to behave. Knox (1989) argued

that "a school provides not a perfectly normal situation, but a highly unnatural environment" (p. 143). Valles and Oddy (1984) found in a follow up study 34 refusers that "whether the child returned to school or not made little difference to later adjustment at work ...[and] only a small difference in terms of the ability to engage in an active social life" (p. 42). It may be that a forced return may not be needed and could even be harmful.

#### B. Reframing with Positive Connotation (RPC)

Watzlawick et al. (1974) and Fisch et al. (1988) provide the basis for the RPC technique used in this research. Watzlawick et al. (1972) defined reframing as changing "the conceptual and/or emotional setting or viewpoint in relation to which a situation is experienced and to place it in another frame which fits the 'facts' of the ...situation equally well" (p. 95). What is changed as a result of reframing is "the meaning attributed to the situation, and therefore its consequences" (p. 95). The family engages in problem-solving in ways that make sense in terms of their shared construction of reality. Thus, reframing interrupts the usual way of problem-solving of family members by attributing a new meaning to the symptomatic behavior-- a meaning which changes how they think about the problem and therefore how they act.

Positively connoting a symptom means to point out "the good side of having such a symptom" (Hill, 1987, p. 266). Pioneering work with positively connoting a symptom was

done by Selvini-Palazzoli, Cecchin, Prata and Boscolo (1978). In their work it is the system which is reframed rather than an individual's behavior. Shoham-Salomon et al. (1987) comment that a positively reframed symptom is "perceived as indicative of the person's virtues" (p. 23). Problems are perceived to be interactional and nonpathological. With RPC an attempt is made to redefine a symptom as good or virtuous but in a way that directs attention to the interactional context of the symptom. The counsellor draws attention to how the symptom is supporting or protecting the family or how the symptom bearer's actions show him/her to be positively representing the family. According to L'Abate (1984), RPC makes it easier for the family to accept control over the symptom.

Several authors (Hill, 1987; Kraft et al., 1985; L'Abate, 1984; Shoham-Salomon et al., 1987) have concluded that RPC may be sufficient in producing change without combining it with other techniques. Kraft et al. (1985), in their study involving 47 depressed college students, concluded that "labeling the client's behavior positively is not only better than labeling it negatively but also better than not labeling it at all" (p. 620). Shoham-Solomon et al. (1987) did a meta-analysis of 12 data sets and found the most significant effect to be for the technique of positively connoting symptoms.

Only a few studies have examined school refusal from a constructivist systemic perspective. Reframing has been

discussed as a tool for use with a school population by Bowman and Goldberg (1983). However, only one of the three cases discussed by them had anything to do with school attendance and the reframe was only intended to create a situation in which the mother would agree to begin therapy. Their cases did involve positive connotation in which a "sense of hopefulness is generated by an approach that focuses on the future while validating the past" (p. 214). Once RPC was used, recommendations or further counselling followed. The reframe was seen as a means of preparing the ground for further work rather than as instrumental in promoting change.

Hawkes (1981) used RPC with a 12 year old boy who was refusing to attend school. The child was positively reframed as being super-sensitive to family needs and wishing to protect them. However, the school refusal was negatively reframed as showing immaturity on the child's part. Again, the reframing was seen as precursor to other interventions. In this case, a gradual desensitization program was also utilized. The combination of positive and negative reframing with desensitization makes it difficult to determine the cause of the changes produced.

Hsia (1984) also used a number of different techniques with a 15 year old refuser. Hsia conceptualized school refusal on "a continuum of progression from 'involuntary' symptoms on one end to 'willful refusal' on the other" (p. 361). The case she discussed involved a 12 year old girl.



The mother had considered her daughter as incapable and helpless. This was reframed negatively as defiance on her daughter's part rather than inability. In addition, the counsellor recommended consequences for non-attendance, provided contact lenses for the child, encouraged the parents to demand attendance and arranged for school personnel and other students to help with school work. Although Hsia was successful, it is impossible to determine the differential effectiveness of the various techniques employed or to know if only this particular combination of interventions would have worked.

Two cases have been reported which used hypnotic interventions along with strategic or paradoxical perspective with school refusers (Kelemen, 1988; Lind, 1987). Kelemen (1988) presented the case of a 12 year old boy. Symptom prescription (the child was asked to continue the school avoidance) and hypnotic suggestion were used. Lind (1987) commented that with "many cases of school phobia, children can be conceptualized as protecting a parent" (p. 96). Consequently, she reframed a child's anxiety as a control problem in which the child could only overcome his problem by becoming his own person and by taking responsibility for his own problems. Hypnosis was used with the aim of general relaxation. However, it is unclear in both of these cases just how significant the role of hypnosis was or how influential the strategic and paradoxical elements were.

Kolko et al. (1987) presented the case of a 6 year old girl who preferred being in the principal's office. Being in the principal's office was reframed as a time for her to learn the skills necessary to take part in the classroom. However, Kolko et al. (1987) conceptualized what they were doing in behavioral as well as family systems terms. Thus, the girl's work in the office was a shaping process and an opportunity to reinforce appropriate school behaviors. The authors saw what they were doing as an emphasis on context as opposed to intrapsychic conflicts. However, blending approaches makes determining differential effectiveness impossible.

In the case of a 15 year old girl presented by Carrow (1989), the child's mother and the principal had focused their attention on the negative effects of the girl's non-attendance on her family and her education. The counsellor shifted the focus to the girl by asking her to choose what was to happen. Instead of having to respond to the perceptions of others, the girl was now presented as capable of making her own decisions. The counsellor told the mother that it was clear that she cared about her daughter because she was giving up her time to come to the school and that the daughter needed to have some time to think about what she wanted to do (as opposed to obstinately refusing to comply). Thus, the usual pattern of problem solving (trying to convince the girl of the reasons for attending) was interrupted.

Although the cases discussed above suggest that RPC may work with school refusers, the evidence is scanty at best. There is a clear need for research which focuses on this form of reframing exclusively without other confounding intervention variables.

#### Summary

The literature has several gaps which are addressed in the current research. An important failing has been that authors have often failed to provide an operational definition of school refusal. Most studies have been single case studies which have relied on anecdotal accounts of changes. When more objective data have been collected, school attendance was the predominant source of information. Very little information has been gathered concerning changes that may have occurred in the child or his family. We do not know if there are other effects produced by particular treatments in addition to the effects related to school attendance; what has been reported in this respect has been in the form of anecdotal accounts presented by the counsellors. When a variety of techniques are combined, determining the effectiveness of each of the constituent techniques is difficult. There has been a dearth of multiple case and comparative studies reported in the literature.

The research reported in this study is a comparison two groups. Each group is treated with a different intervention strategy (SD and RPC). While attendance was a

part of the data considered, data were also collected to determine if the treatments caused changes in family relationships, in parents attributions about the causes of the school refusal, in parents' perceptions of their child's problematic behavior and in the anxiety level of the child . Determining whether or not the SD and RPC treatments influenced the clients in different ways was an important research question in this study.

From the literature review presented above, it is apparent that the SD method has much more credibility as an effective technique with school refusers than the RPC method does. Therefore, the other main research question was whether or not the RPC treatment would perform as well as the more established SD treatment.

## Chapter III

### Method

There were two independent variables: the Systematic Desensitization (SD) treatment and the Reframing with Positive Connotation (RPC) treatment. There were two types of dependent variables: outcome variables indicating the degree of success of the interventions and process variables which provided information about the quality of changes. The former were measured using three instruments which assessed the impact of the treatments: 1) attendance was checked before the counselling interventions began and after they were completed; 2) Achenbach's (1988) Child Behavior Checklist (CBC) was used to determine change in behavior as perceived by parents; 3) the Revised Children's Manifest Anxiety Scale (RCMAS) (Reynolds, 1985) was used to determine if change took place in the rating of the child's anxiety. In addition, two instruments were used to explore process variables: 1) the Causal Dimension Scale for Close Relationships (CDSCR) (Grunau & Horvath, 1990) was used to determine changes in parents' attributions about the causes of the school attendance problem; 2) Benjamin's (1988) Structural Analysis of Social Behavior (SASB) was used to determine if there was a change in the relationship between the participating parent and the child.

### Subjects

A total of 25 students (see Results chapter for descriptive statistics for these subjects) participated in the study; 19 of these completed all four counselling sessions. Of this 19, nine received the SD treatment and 10 the RPC treatment. Data were collected from January 1990 to April 1990 and from September 1990 to December 1990. The 6 subjects who did not complete the counselling sessions were all assigned to the SD condition during the first data collection period. Since all the drop-outs were from the SD condition alterations needed to be made to the manual for this condition. The major problem with the original SD manual seemed to have been that the clients were asked to move too quickly from a discussion of the problem to accepting the rationale for the treatment and practicing the relaxation method. The nine who completed the SD treatment all received the revised version of the treatment during the second data collection period. The subjects during the first data collection period were assigned to treatment groups on an alternating basis starting with the SD group. All subsequent subjects were assigned randomly to the two interventions (SD and RPC) by drawing a number from a container with 24 slips in it: eight were labeled RPC and 16 were labeled SD.

The author made contact with the school personnel over the telephone or through a group presentation. The type of subject sought was described in this telephone

conversation as follows:

The study offers two counselling programs for dealing with the problem of school refusal. School refusers are defined in this study as being anxious about school or having a high level of discomfort about school. This does not necessarily mean that they will be total non-attenders. If it can be determined through a combination of reports from teachers, counsellors and parents that the child is suffering great discomfort and doing such things as causing scenes before going to school, then the child could be included in the study. The child should not be delinquent or conduct disordered or "acting out" in other areas besides their school attendance problem.

### Setting

This study was undertaken in three school districts in British Columbia. Students who participated in the study were referred by school counsellors. A written description of the project was given to the parents and their children. Parents were required to sign an informed consent form before counselling began (See Appendix C).

The research team had three members: 1) the senior supervisor who was available for consultation, 2) the graduate student author of this study, 3) a second graduate student who took part during the first data collection period and who only completed cases using the

RPC method. The two graduate students conducted counselling sessions and administered questionnaires.

Both the SD and the RPC groups received four one-hour counselling sessions. In every case at least one parent took part in the counselling sessions with their child. The first three sessions were conducted on a once a week basis. During the fourth week, the in-person meeting between counsellor and clients was replaced by a telephone interview; the fourth week was seen as time for the clients to practice skills or assimilate new ways of thinking about the school attendance problem. The fourth in-person counselling session involving both parents and children, was conducted during the fifth week. Six cases were completed during the first period and thirteen during the second period.

### Procedure

The procedures for each treatment group were prepared in advance in the form of counselling intervention manuals written by the author (See Appendixes A and B). The author and the graduate student helper met on four occasions before the study began to review the procedures in the manuals and to practice certain key sections through role-playing.

At the first meeting, parents were given a written explanation of the study (see Appendix C). Children nine years old or older were also given the written explanation to read while younger children had the study explained to



them orally. Once written consent had been given, parents were asked to fill out questionnaires and the first counselling session commenced.

The counselling took place in the family home or in the school or, in some cases, sessions were divided between school and family homes. Most often, parents decided where to meet. Sometimes, after the initial session the counsellor requested that meetings switch scenes if it was felt that the meeting could be better conducted in either the home or the school.

Data, for both the SD and RPC groups, were collected according to a pre-established format:

Session 1: the CBC, the SASB and the CDSCR were completed during the first session by parents; the child completed the RCMAS.

Session 2: data were not collected.

Session 3: the WAI was completed by parents.

Session 4: the SASB and the CDCSR were completed for a second time.

During the initial data collection period (January to May 1990) the CBC and the RCMAS were also completed in the fourth session. In the second data collection period (September to December 1990), due to concerns about overloading the clients with questionnaires, the CBC and RCMAS were postponed until six to eight weeks after the counselling ended.

### Systematic Desensitization (SD) Procedures

Session 1. There were three goals: 1) to explore the problem and establish rapport with the clients, 2) to give a rationale for using the SD method, and 3) to assess the child's ability to visualize . Questions were asked about what was happening currently with the school refusal rather than about past events which may have caused the problem. Establishing rapport with the clients through joining was part of this problem exploration stage: "Joining is letting the family know that the therapist understands them and is working with and for them" (Minuchin & Fishman, 1981, p.31). The counsellor further facilitated the process of establishing rapport by attending to what the clients were saying, by using the sort of language that they used and by showing interest in things which were of importance to them. The rationale emphasized that people often encounter situations that make them uncomfortable but that it was possible to learn a way of controlling these feelings. Ability to visualize was assessed by asking the child to imagine a scene followed by questions to determine if they were able to do so or not (see Appendix A for further details). As a between session homework assignment, the parent was asked to help the child produce a five item list of things (such as a toy) or places (such as their bedroom) that the child associated comfort or relaxation with.

Session 2. There were two important counsellor activities in this session: teaching relaxation and developing a hierarchy of anxiety producing stimuli. A combination of imagery and deep muscle relaxation was used (Deffenbacher et al., 1988; Emmelkamp, 1982; Hatzenbuehler et al., 1978; King et al. 1990; Stedman, 1976; Wolpe, 1958) as a method of relaxation. The children were asked to produce a list consisting of between four and eight items related to their anxiety about school. Items included such things as being called upon to answer a question in class or preparing to go to school. The child arranged the items in a hierarchy from least anxiety producing to most anxiety producing. These items were presented starting with the least anxiety producing and progressing through to most anxiety producing. As each situation was presented an incompatible relaxed state was induced. If the child, in the counsellor's judgement, had difficulty producing imagery he/she would be exposed to the actual situations and given some concrete object associated with a relaxed state such as a doll to bring with them as they were exposed to the stimuli. The homework assignment was to practice the relaxation with the first two items on the hierarchy.

Session 3: The goal of this session was to continue teaching the parent(s) how to teach the child to relax in the presence of hierarchy items. The parents were asked to conduct the relaxation exercises in conjunction with

the hierarchy items during the session and the counsellor acted as an advisor to the parent. Other important counsellor activities were discussing experiences arising from the homework and encouraging continued practice. The session ended by setting a time for the telephone contact.

Telephone contact: During the phone conversation the counsellor helped the parents to solve any problems arising from the between sessions practices. In addition, the counsellor made supportive comments and encouraged the parents to continue practicing with their child.

Fourth session: The goals of this session were to review what had taken place so far and to do additional problem solving if needed. The child was asked how he/she might cope with his/her worst imaginings of what could go wrong in school by using the relaxation method. If the children brought up fears that had not been addressed, it would be pointed out that they had now learned a method of coping with these fears: they could implement the relaxation procedures to deal with other things that might make them anxious.

#### Reframing with Positive Connotation (RPC) Procedures

The RPC method consisted of five steps: 1) defining the problem, 2) identifying attempted solutions, 3) setting goals in concrete terms, 4) delivering the reframe with positive connotation and 5) follow up and consolidation. These steps do not necessarily coincide with particular sessions but the treatment was conceptualized as

progressing in order through these steps. Again, as with the SD method, there were four sessions and a telephone contact between the third and fourth sessions. The method used was similar to that presented by Fisch et al. (1982) and followed the principles put forth by Watzlawick et al (1974).

The counsellors' stance was important in creating the conditions conducive to defining the problem (step one). A problem solving approach was used which emphasized events which were currently causing problems as opposed to seeking causes in the past. Implied in this position is a non-blaming attitude conveyed by the counsellor who said something like, "it is assumed that no one is malicious and that each of you is doing the best that you can". The counsellor also took a "one-down" or consultant's stance which sought to convey the idea that the participants were the "experts" in their situation. In addition, joining (as described above with the SD procedures) was employed to help build an alliance between counsellor and clients.

Step 1: The goal at this stage involved arriving at an agreed to statement of the problem in terms that would be amenable to change. Problem exploration leading to goal setting was accomplished through asking questions such as, "How is it a problem for you?" or "What is the most important difficulty for you at this time?" or "How would things be different if the problem disappeared?".

Step two: The goal here was to identify the previously attempted solutions to the problem. The assumption was that the way people have tried to solve their problems can lead to an understanding of what supported the problem and that the reframe would need to interrupt these attempted solutions. Questions such as, "what have you tried already to solve this problem?" were asked.

Step 3: The purpose here was to arrive at an agreement in concrete, specific terms regarding the goals of the counselling program. A statement such as, "I want Billy to be able to go into the classroom without me accompanying him and without spending 15 minutes crying", was sought.

If some of the above three steps were not accomplished during the first session, work towards satisfying the goals of the steps continued in subsequent sessions until the goals were met.

At the end of the first session a homework assignment was given. The parents were asked to observe a typical family interaction involving the school refusing child and to record their observations in a log provided by the counsellor. The parents were asked to pay attention to who said what to whom, what led up to the event and to the outcomes of the interchanges. The log was used for discussion purposes in the second session.

Step 4: The goal at this stage was to deliver the reframe (this was done during the second or third session). The interactional cycles presented by the family were re-stated in positive terms. Most often, the reframe was an opportunity to explore some positive aspects of the child's non-attendance at school. For example, in the case of father and son who were in conflict over the son's school refusal the counsellor said something like, "your son's staying at home has provided an opportunity for you to demonstrate your concern and support for him while for your son it is an opportunity to build up his confidence in preparation for returning to school". Thus, instead of a power struggle the situation was reframed as a chance to improve their relationship and there was an implication that the son would be returning to school.

The homework assignment after the reframe was to further explore possibilities suggested by the reframe and to notice any differences in the family interactions. This was to be noted in the log and shared in subsequent sessions.

Step 5: This step was aimed at consolidating the reframe and following up on any issues that arose between sessions. (This step may have been undertaken as early as the second session but was always accomplished by the fourth session.) Thus, the counsellor would continue to emphasize positive aspects of the symptomatic behavior and

would connect the reframe to the issues brought up in subsequent sessions or during the telephone contact.

### Measures

As mentioned above, three instruments were used to assess the impact of the treatments: 1) attendance, 2) the Child Behavior Checklist (CBC) and 3) Revised Children's Manifest Anxiety Scale (RCMAS). Two instruments were used to assess qualitative changes in process variables: 1) the Causal Dimension Scale for Close Relationships (CDSCR), 2) the Structural Analysis of Social Behavior (SASB). In addition to the outcome and process variables, the Working Alliance Inventory (WAI) (Horvath, 1981) was used as a control to measure the influence of client-counsellor relationship factors.

Attendance. Pupil's attendance before counselling sessions began and after the counselling ended was collected. The information was provided by school personnel and taken from official school records. Varying amounts of information were available depending on whether the school year had just begun or had been in progress for some time. A minimum of 19 days were surveyed for pre-attendance and 15 days for post-attendance. The attendance data were converted to percentages.

Child Behavior Checklist (CBC)--Parent's Version (Achenbach, 1988). This instrument purports to measure behavior disturbance in children aged 5 through 16. There are 118 items to be filled out by parents or parent



surrogates. The CBC has been subjected to considerable empirical investigation (Achenbach & Edelbrock, 1983; Cartledge & Milburn, 1986) and found to have a high test-retest reliability. The median Pearson correlation for 1-week test-retest reliability was .89. When each of 110 test items was compared in a 1-week test-retest situation, 21 comparisons were significantly different (11 would be expected by chance). Thus, there was a small tendency to report fewer problems at second ratings. Over a 3-month period test-retest correlations for inpatients' scores averaged .74 for parent's ratings.

Construct validity of the CBC was supported (Achenbach, et al., 1983) by comparing this instrument with other parent rated behavior checklists and by comparing demographically-matched referred and non-referred children on the checklist scores. Clinical status accounted for a large percentage of the variance in the scores between the two groups. The CBC has been used in the study of school refusal by Burke and Silverman (1987) and by Kearney and Silverman (1990).

Revised Children's Manifest Anxiety Scale (RCMAS).

Reynolds (1985) using a test-retest method found evidence supporting RCMAS reliability. Internal consistency was estimated to be .83 with a sample of 329 children. Reynolds (1985) also reports factor analytic studies which lend strong support to the construct validity of the RCMAS. The RCMAS was also found to have high validity

coefficients (.78 in one comparison) with other measures of anxiety in children such as the State-Trait Anxiety Inventory for Children (Spielberger, 1973).

Both the CDSCR and the SASB consist of several subscales and would require a much larger sample size than was obtained in this study to be analyzed statistically. Nevertheless, changes from pretest to posttest provided useful information for describing changes in parents' thinking about the school refusal problem.

Causal Attribution (CDSCR). Grunau and Horvath (1990) developed this scale based on Russell's 1982 Causal Dimension Scale with the difference that the CDSCR is designed to access attributions in close relationships. The CDSCR has seven subscales: self-other, self-circumstances, stability, globality, control, intent and attitude. In this study a modified version of the CDSCR was used which yielded the same seven subscales but had only one question instead of three from which to calculate a score on each subscale. Since the focus of the RPC treatment was on changing how parents were thinking about their children's school attendance problem, this instrument was given to parents rather than to children. Also, some of the children in the study would not have been able to complete the instrument due to their age. The CDSCR consists of seven subscales each representing a dimension of causal attribution: 1) self-circumstances, 2) self-other 3) stability, 4) globality, 5)

controllability, 6) intentionality and 7) attitude. In this study the parents evaluated this measure. Changes in scores from pretest to posttest on the subscales suggest the following: 1) self- circumstances: an increase indicates the cause of the problem has been attributed to the self (parent) while a decrease indicates the cause was attributed to circumstances (such as having a poor teacher or an illness); 2) self-other: increased scores suggests greater responsibility was given to the self (parent) as the cause of the problem as opposed to attributing the cause of the problem to the other (the child); 3) stability: an increase suggests that the problem was perceived as stable or less likely to change and a decrease suggests that the cause was seen to be more unstable or changeable; 4) globality: increased scores indicate the cause of the problem was perceived as more global (for example, attributing the cause to the school system without specifying what aspect of the school) and a decrease shows that the cause tended to be something more specific (such as the child is anxious about the teacher); 5) controllability: an increased score means the problem was viewed as more controllable and a decrease means the problem was perceived to be less controllable; 6) intentionality: an increased score suggests the problem was intentionally caused and therefore blame could be attached to the person causing the problem; a reduced score indicates that the problem occurred without anyone

intending it to; 7) attitude: an increased score indicates a more negative or selfish attitude; a decreased score shows a more positive or less selfish attitude concerning the cause of the problem.

Structural Analysis of Social Behavior-- Short Form (SASB) (Benjamin, 1988). SASB is a system for conceptualizing and analyzing interpersonal relations. It reduces the interpersonal and intrapsychic domains to three essential components: Focus, Affiliation and Interdependence. The three surfaces or focuses are: 1) The transitive or other focus which is conceived of as prototypically parental, concerns actions to or for another person. For example, the questionnaire item "She neglects me, my interests and needs," is focused on the other. 2) The self or intransitive focus is prototypically childlike and involves behaviors which are reactive and concerned with what is going to be done for, to or about the self. The complementary item to the previous example from the self surface states, "I wall myself off from her; don't hear; don't react". 3) The introject focus, unlike the other two, does not focus on relationship but on a sense of self, on intrapsychic factors. An example with a complementary item for the introject surface is, "I neglect myself; don't try to develop my own potential skills, ways of being".

SASB also has two "dimensions": one is affiliation and the other is interdependence (Humphrey & Benjamin,

1986). The affiliation axis extends from friendly and loving on one side to hostile and attacking on the other side (referred to in this study as the Friendliness-Attack axis). Interdependence is on the other axis and ranges from independent at the top to interdependent at the bottom (referred to as the Give-Autonomy-Control Axis).

SASB is a self-report instrument structured in a true/false format. The rating is made on a 0-100 scale in 10-point increments. From 0 to 40 indicates false and from 50 to 100 true. The rater (in this study the rater is always a parent) rates the self and a significant other (the school refusing child) for situations described as "best" or "worst". In this study, a modified version of the standardized Short Form was used which left out the sections asking the rater to rate his/her own parents.

The SASB model arises out of interpersonal circumplex theory (Benjamin, 1989; Humphrey & Benjamin, 1986; Kiesler, 1982) and has been validated by a number of methods including factor analysis, autocorrelational techniques, dimensional ratings procedures, circumplex analyses, and correlations with criterion measures (Benjamin, 1989). Within subjects test-retest reliability was checked with undergraduate students for the various groups of questions with results between .655 and .894 (Benjamin, 1988). Similar test-retest results have also been reported for various populations of adults. However, none were available indicating reliability for use with

parents and children. Construct validity was checked using factor analysis (the range in percent of variance accounted for by the two factors ranged from 54.5% to 69.4%). Discriminant validity has been supported by comparisons among experimental groups.

Working Alliance Inventory (WAI). This instrument is designed to measure relationship variables that may affect the success of counselling (Horvath, 1981). Horvath and Greenberg (1989) report an adequate level of reliability for the WAI (estimates based on item homogeneity ranged from .85 to .88 for subtest populations and a composite alpha yielded .93). They also reported strong associations between the WAI and other similar inventories which suggests convergent validity.

## Chapter IV

### Results

Five dependent measures were taken before and following both treatments: school attendance, the Child Behavior Checklist (CBC, Achenbach, 1988), the Revised Child Manifest Anxiety Scale (RCMAS, Reynolds et al., 1985), a shorted version of the Causal Dimension Scale for Close Relationships (CDSCR, Grunau & Horvath, 1989) and a modified form of the Structural Analysis of Social Behavior-- Short Form (SASB, Benjamin, 1988). In addition, the Working Alliance Inventory (WAI, Horvath, 1981) was completed. Attendance and SASB data were obtained for all 19 cases (SD=9, RPC=10). For the CDSCR there were 18 complete sets (SD=9, RPC=9). However, for the CBC and the RCMAS only 16 subjects completed the questionnaires at both pretest and posttest (SD=8, RPC=8).

The results are presented below as follows: First, demographic variables are reported. Next, the results of tests of differential effectiveness of the two counsellors are summarized. A comparison of the cases completed during the first data collection period with the cases completed during the second data collection period follows this. Results concerned with the differential efficacy of the treatments-- attendance, CBC, and RCMAS-- follows next. Following this, the results from the process instruments CDSCR and SASB are given. Finally,

counsellor-client relationship factors as measured by the WAI are presented.

Subjects ranged in age from 5 years to 15 years with the mean age of 10.9 years. The age range for the SD treatment was 5 to 15 with a mean age of 10.6 years; the age range for the RPC group was 5 to 15 with a mean of 11.2 years. Children in the SD group were in grades one to nine; children who received the RPC treatment were in grades Kindergarten to nine. Overall there were 13 male and 6 female children in the study. In the SD condition there were six males and three females; in the RPC condition there were seven males and three females. Of the eight single parent households, four were in the SD group (one father and three mothers) and four in the RPC group (all mothers). The mean number of siblings in the SD condition was 1.8 and in the RPC condition it was 1.5.

The differential effectiveness of the two counsellors was analysed. There were no significant differences between the counsellors when a counsellors (2) x time (2) analysis of variance was calculated using the children's school attendance, the CBC and the RCMAS as dependent variables.

A comparison of the first data collection period (January to May 1990) with the second (September to December 1990) was done for attendance, the CBC and the RCMAS. For all three measures the difference between pretest scores and posttest scores was calculated. A



analysis of the differences between the means was computed using t-tests. There were no significant differences for attendance ( $t= 1.2$ ;  $df= 18$ ;  $p= .2$ ), the CBC ( $t= -1.65$ ;  $df= 15$ ;  $p= .1$ ) or the RCMAS ( $t= -.87$ ;  $df= 15$ ;  $p= .05$ ).

Rates of attendance were calculated by dividing the actual attendance of a child by the possible attendance for a period of time (minimum 19 school days) before and after treatment. The mean attendance percentages are reported in Table 1 and Figure 1. A time (2) x treatment (2) analysis of variance was calculated (reported in Table 2) but did not yield any significant results ( $p > .05$ ). Changes were in the expected direction.

The scores on the CBC are reported as mean T-scores and are found in Table 1 and Figure 2. A time (2) x treatment (2) analysis of variance was calculated (see Table 3) which yielded a significant effect for time (pretest and posttest scores compared for the combined groups) ( $F= 6.24$ ;  $df= 1, 14$ ;  $p < .05$ ). However, there were no significant differences between the treatments ( $F= 1.27$ ;  $df= 1, 14$ ;  $p > .05$ ) nor was there an interaction between treatments and time ( $F= .09$ ;  $df= 1, 14$ ;  $p > .05$ ). Thus, there was an overall significant improvement for both treatments, but each treatment group changed about the same amount.

The scores from the RCMAS are reported as mean T-scores in Table 1 and Figure 2. A time (2) x treatment (2) analysis of variance was calculated (see Table 4).

However, there was a significant interaction between the treatments ( $F= 8.41$ ;  $df= 1, 14$ ;  $P < .05$ ). There was no significant difference between the treatments ( $F= 1.38$ ;  $df= 1, 14$ ;  $p > .05$ ) or from pretest to posttest ( $F= 4.49$ ;  $df= 1, 14$ ;  $p=.05$ ). While a significant difference between the treatments was not found, all the change that occurred was for the SD condition. Therefore, it is clear that the changes for the SD condition produced the significant interaction found.

The process variables, SASB and CDSCR, have a large number of subscales which, in conjunction with the small sample size, indicated that there was insufficient statistical power to do meaningful parametric analysis. Therefore, the differences between the two treatments in direction of change for the CDSCR and the SASB are treated descriptively rather than analyzed statistically. The SASB and the CDSCR were used to explore shifts in parents' attitude.

Prior to the study four shifts were predicted for the SD group on the CDSCR. On the self-circumstances subscale a shift towards circumstances was expected because environmental or circumstantial factors were emphasized in the treatment. On the self-other subscale a shift towards the other pole was expected since the focus of the treatment was on the child (other pole). A change towards an increased sense of control was hypothesized for the controllability subscale because of the parents' increased

Table 1  
Pretest and Posttest Means for the Dependant Variables  
of Attendance, CBC and RCMAS for Each Treatment (SD, RPC)  
Condition

Instrument	Pretest		Posttest	
	Mean	SD	Mean	SD
<u>Systematic Desensitization Condition</u>				
Attendance	51.6	38.5	59.7	44.2
CBC	66.13	5.87	62.88	4.97
RCMAS	60.00	10.10	50.38	8.03
<u>Reframing with Positive Connotation Condition</u>				
Attendance	50.5	35.4	62.6	36.1
CBC	63.00	8.9	58.88	7.5
RCMAS	48.38	14.1	49.88	10.9

Note. The values for Attendance represent mean percentages. The values for the CBC and RCMAS represent mean T-scores.

Table 2  
Treatment (2) x Time (2) Analysis of Variance for  
Repeated Measures with Mean Attendance Percentages

Effect	DF	MS	F	P
Between-Subjects Within Cells	17	.27		
Treatment (Tr)	1	11.94	.00	.96
Within-Subjects Within Cells	17	.03		
Time (T)	1	.10	3.67	.07
Tr x T	1	.00	.15	.71

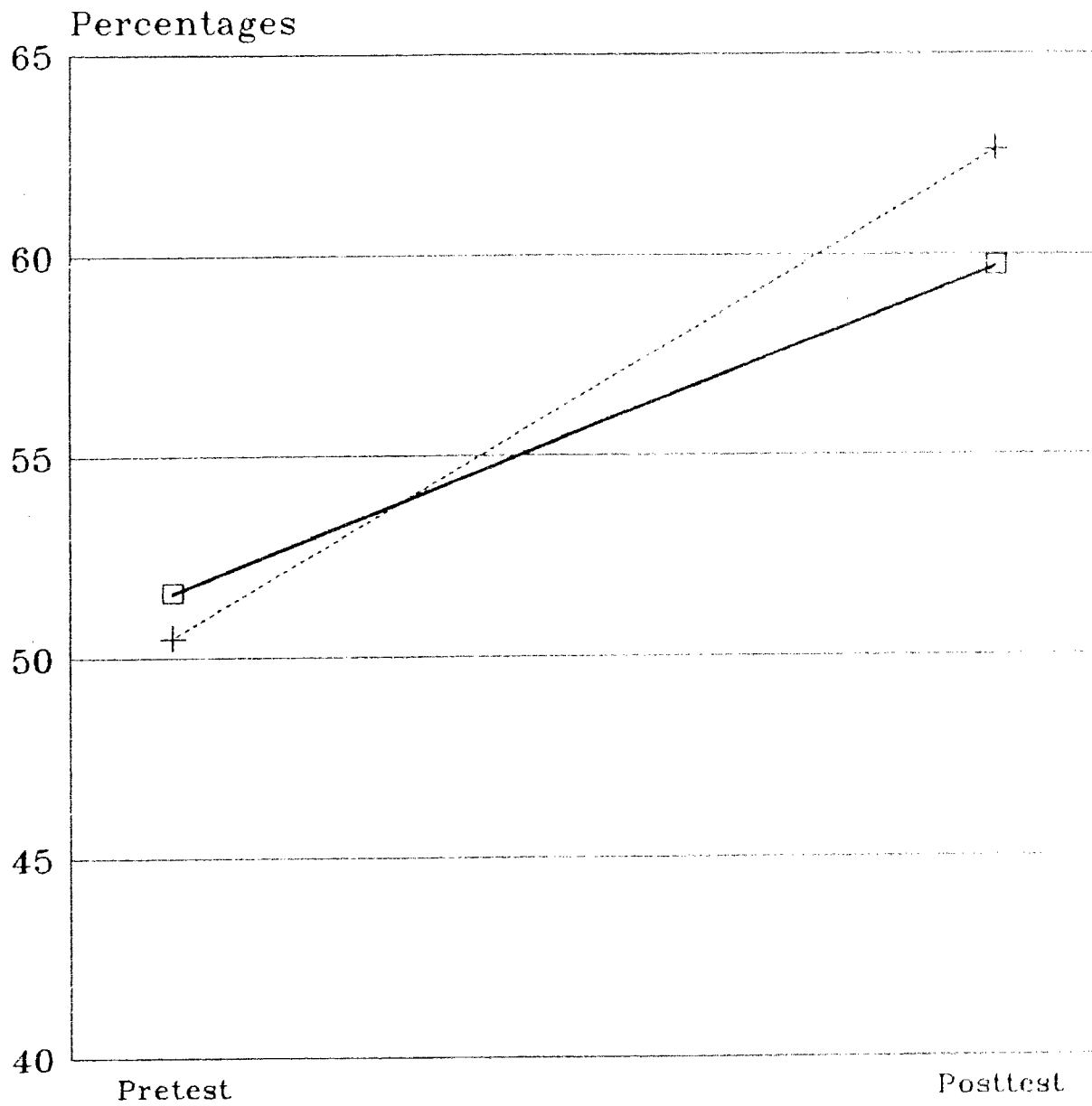
Table 3  
Treatment (2) x Time (2) Analysis of Variance for  
Repeated Measures with the Child Behavior Checklist  
(CBC)

Effect	DF	MS	F	P
Between-Subjects Within Cells	14	79.75		
Treatment (Tr)	1	101.53	1.27	.28
Within-Subjects Within Cells	14	17.44		
Time (T)	1	108.78	6.24	.03
Tr x T	1	1.53	.09	.77

Table 4  
Treatment (2) x Time (2) Analysis of Variance for  
Repeated Measures with the Revised Child Manifest  
Anxiety Scale (RCMAS)

Effect	DF	MS	F	P
Between-Subjects Within Cells	14	212.33		
Treatment (Tr)	1	294.03	1.38	.26
Within-Subjects Within Cells	14	29.42		
Time (T)	1	132.03	4.49	.05
Tr x T	1	247.53	8.41	.01

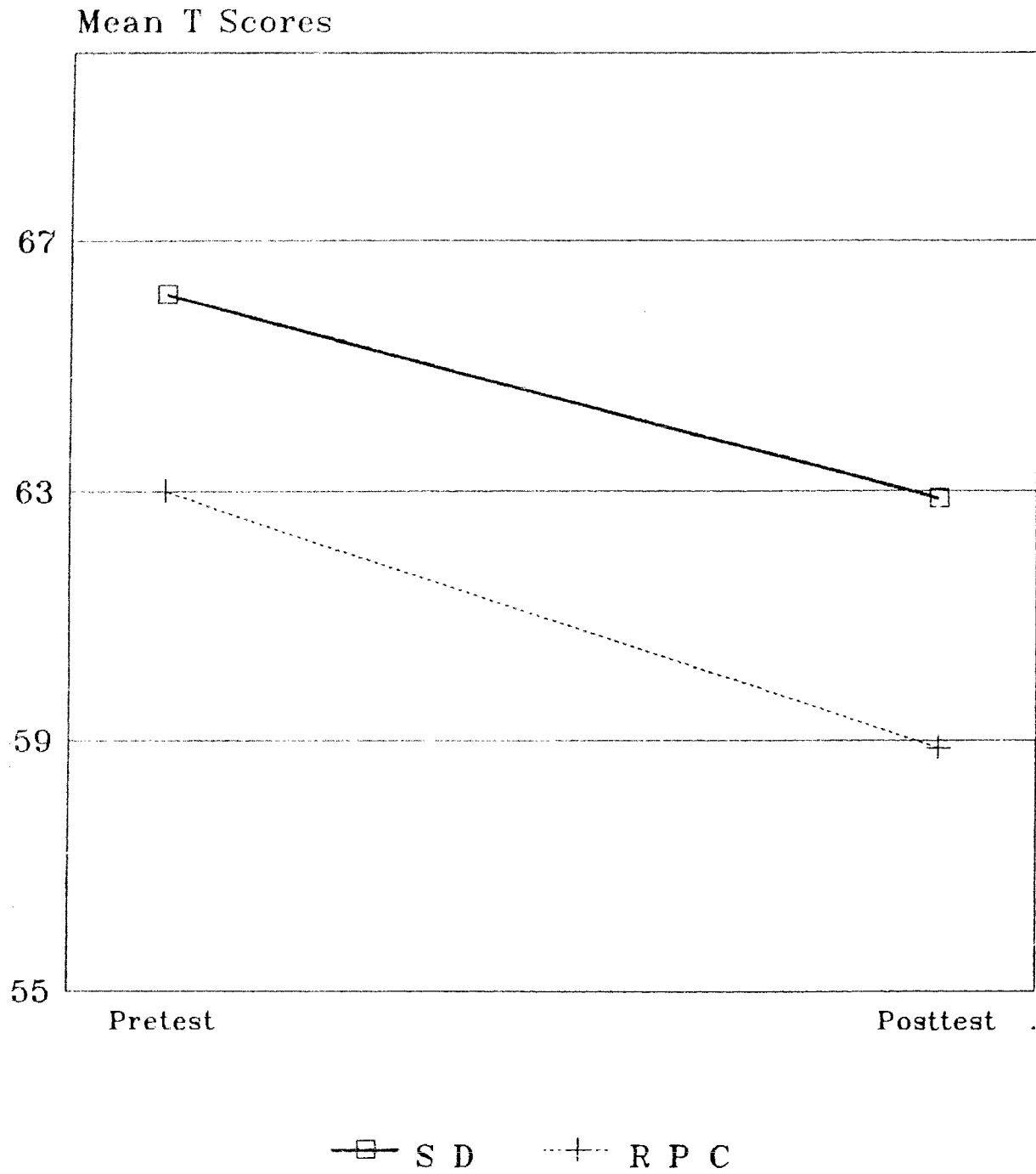
Figure 1  
Attendance



—□— S D    -+ - R P C

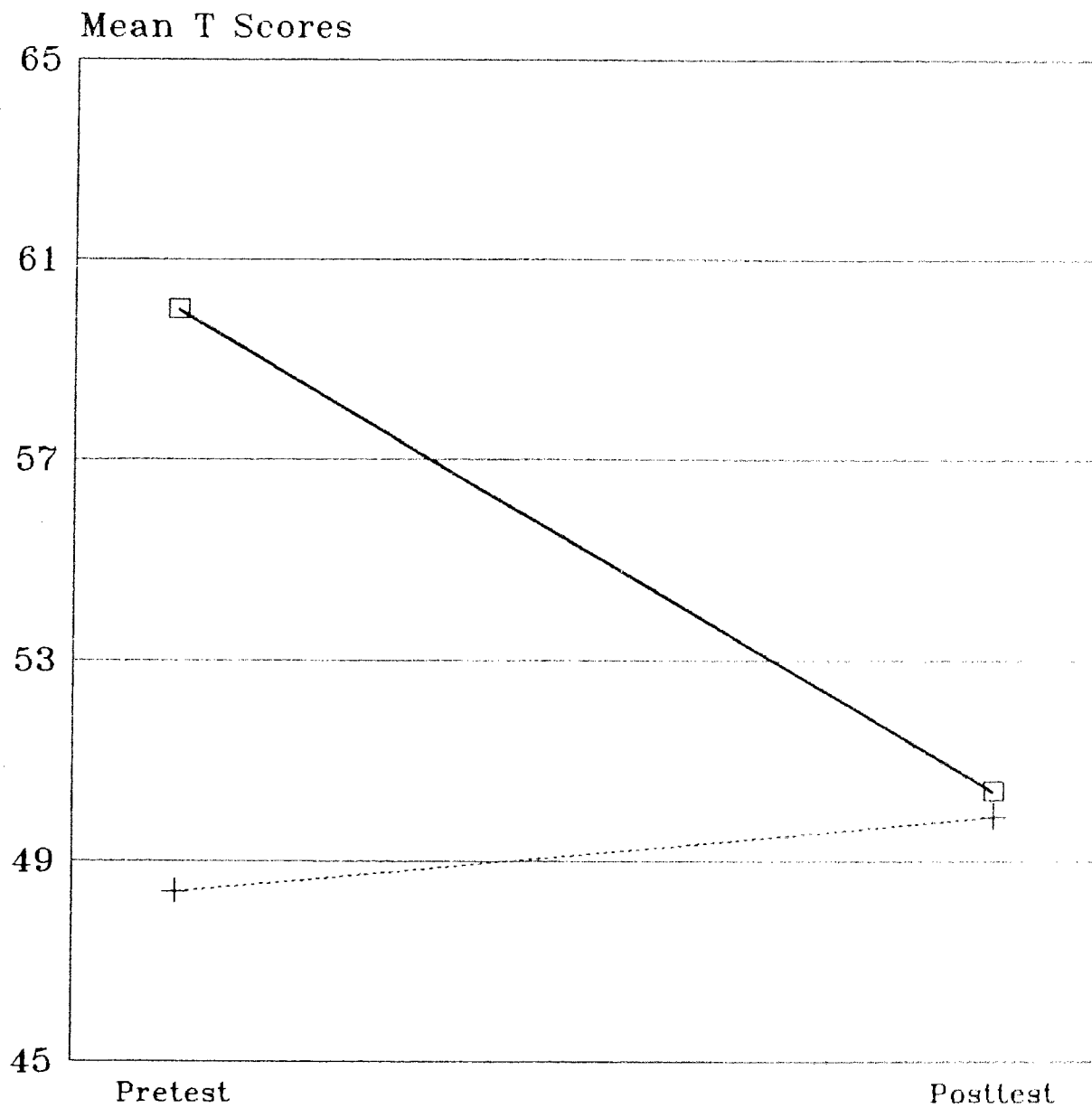
# Figure 2

## Child Behavior Checklist



# Figure 3

## Revised Child Manifest Anxiety Scale



—□— S D    -+ - R P C

involvement in managing their children. A shift towards specificity was expected on the globality subscale since parents and children had been asked to identify particular situations in which the child was anxious. On the stability, intentionality and attitude subscales predictions were not made. Results for the CDSCR are reported in Table 5.

Predictions regarding outcome on the CDSCR for the SD group were as expected only for the self-circumstances scale where parents shifted their rating towards circumstances rather than increased parental responsibility for causing the problem. Predictions contrary to expectations were as follows: On the self-other scale the SD parents evaluated themselves as being more responsible for causing the problem rather than attributing the cause of the school refusal to their children. For the controllability scale the problem was seen as being less controllable at posttest than at pretest. On the globality scale the cause was perceived to be global as opposed to specific.

For the scales for which predictions were not made for the SD group the changes were as follows: On the stability scale these parents indicated a change toward finding the problem to be more unstable or more open to being altered. On the intentionality scale parents



Table 5  
Mean Scores on the Causal Dimension Scale for Close Relationships (CDSCR)

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Systematic Desensitization (n=9)

Sub-scale	Pretest		Posttest	
	M	SD	M	SD
Self-circumstances	2.556	.726	2.444	1.014
Self-other	2.000	.866	2.556	1.130
Stability	3.667	1.225	2.667	1.323
Globality	2.889	1.054	3.222	1.302
Controlability	4.111	.982	3.111	1.364
Intentionality	1.667	1.414	1.444	.892
Attitude	2.778	1.093	2.778	1.563

Reframing with Positive Connotation (n= 9)

Self-circumstances	2.111	.782	2.444	1.424
Self-other	2.556	1.130	2.111	.782
Stability	2.444	1.041	3.444	1.130
Globality	2.444	1.130	3.111	1.537
Controlability	3.667	1.118	3.556	.726
Intentionality	2.444	1.236	2.000	1.000
Attitude	3.000	1.225	2.667	1.118

---

indicated that they saw the cause of the problem to be less intentional at posttest than at pretest. There was no change from pretest to posttest on the attitude scale.

Five shifts were hypothesized prior to the study for the RPC group on the CDSCR: 1) It was anticipated that parents would take more responsibility for the problem on the self-circumstances subscale rather than blaming circumstances since reframing the child's behavior should have resulted in a perception that the children's behavior was more manageable. This greater sense of manageability should have made it easier for parents to take more responsibility. 2) Similarly, parents were expected to take more responsibility as opposed to blaming their children for causing the problem on the self-other subscale. 3) The causes of the problem were expected to be seen as less stable since this would indicate a greater openness to change. 4) It was predicted that there would be a shift towards seeing the cause of the school refusal as more unintended on the intentionality subscale. 5) On the attitude subscale the anticipated shift was towards parents having a more positive attitude. Predictions regarding the outcome of the globality and controllability subscales were not made.

The RPC group changed in the predicted direction for 3 of the 5 scales. There was a shift towards parents feeling a greater sense of responsibility on the self-other scale. Parents indicated that they felt that

less blame was warranted for themselves or their children on the intentionality scale. The third predicted change was on the attitude scale and showed a shift towards a positive attitude towards the problem.

The self-circumstances and stability scales on the CDSCR were contrary to expectations for the RPC group. Circumstances or factors outside parental control were emphasized more at posttest than was parental responsibility. On the stability scale there was a shift towards seeing the problem as more stable and therefore, more unchangeable.

For the two scales for which there were no predictions for the RPC group the results were: The globality scale shifted towards seeing the cause of the problem as more global as opposed to being more specific. On the controllability scale the problem was seen as being slightly less controllable at posttest than at pretest.

The changes from pretest to posttest, in differences in mean scores, on the SASB are presented for the Friendliness-Attack axis in Figure 4 and for the Give Autonomy-Control axis in Figure 5. For all the situations the parents were the raters. When a relationship is rated it is the one between the parent and the school-avoiding child. For all three focuses the rating was done for two types of conditions: an "at best" condition and an "at worst" condition. For the "at best" condition the raters were asked to recall a time when things were going as well

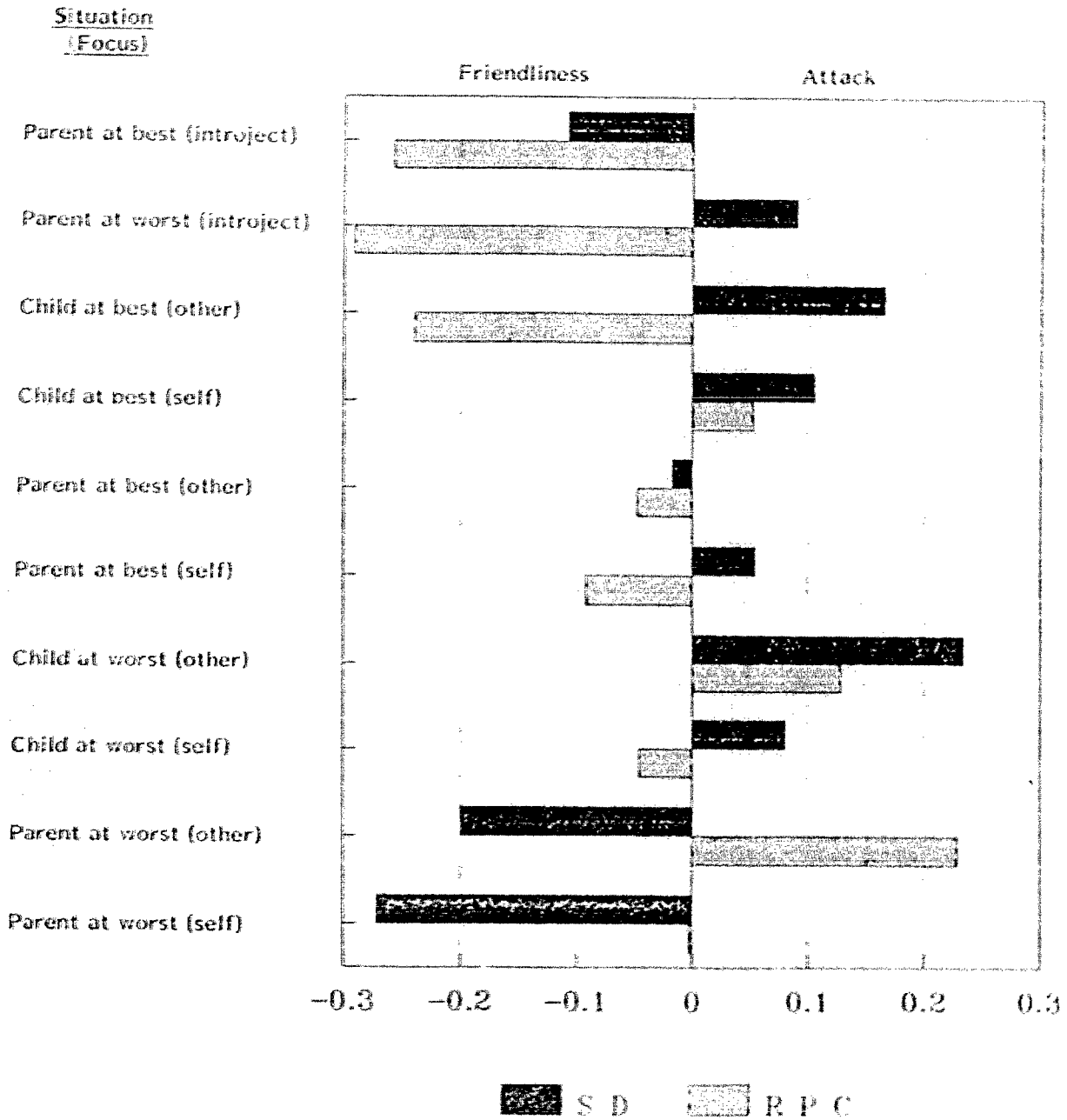
could be expected. For the "at worst" condition raters were asked to recall a time when things were going as badly as they ever do.

In Figures 4 and 5 the ten situations are from top to bottom: 1) introject "at best" where the parents rate themselves, 2) introject "at worst", again the parent is rated, 3) the child "at best" (other focused) or how the child acts towards the parent, 4) the child "at best" (self focused) or how the child reacts to what parent does, 5) the parent "at best" (other focused) or how the parents see themselves acting towards their children, 6) the parent "at best" (self focused) or how the parents react to what their children are doing, 7) the child "at worst" (other focused) or how the child is perceived to be acting towards the parents, 8) the child "at worst" (self focused) or how the child reacts to the parents, 9) the parent "at worst" (other focused) or how the parents see themselves behaving towards their children, 10) the parent "at worst" (self focused) or how the parents feel they are reacting to their children.

All ten of the above situations are rated for each of the two central dimensions or axes (Friendliness-Attack and Give-Autonomy-Control). Results are given in terms of proximity to extremes on the axes. For example, a perfect relationship would be represented by the number one. On the Friendliness-Attack axis with the child "at best" (other focus) situation, for example, a rating of one for

# Figure 4

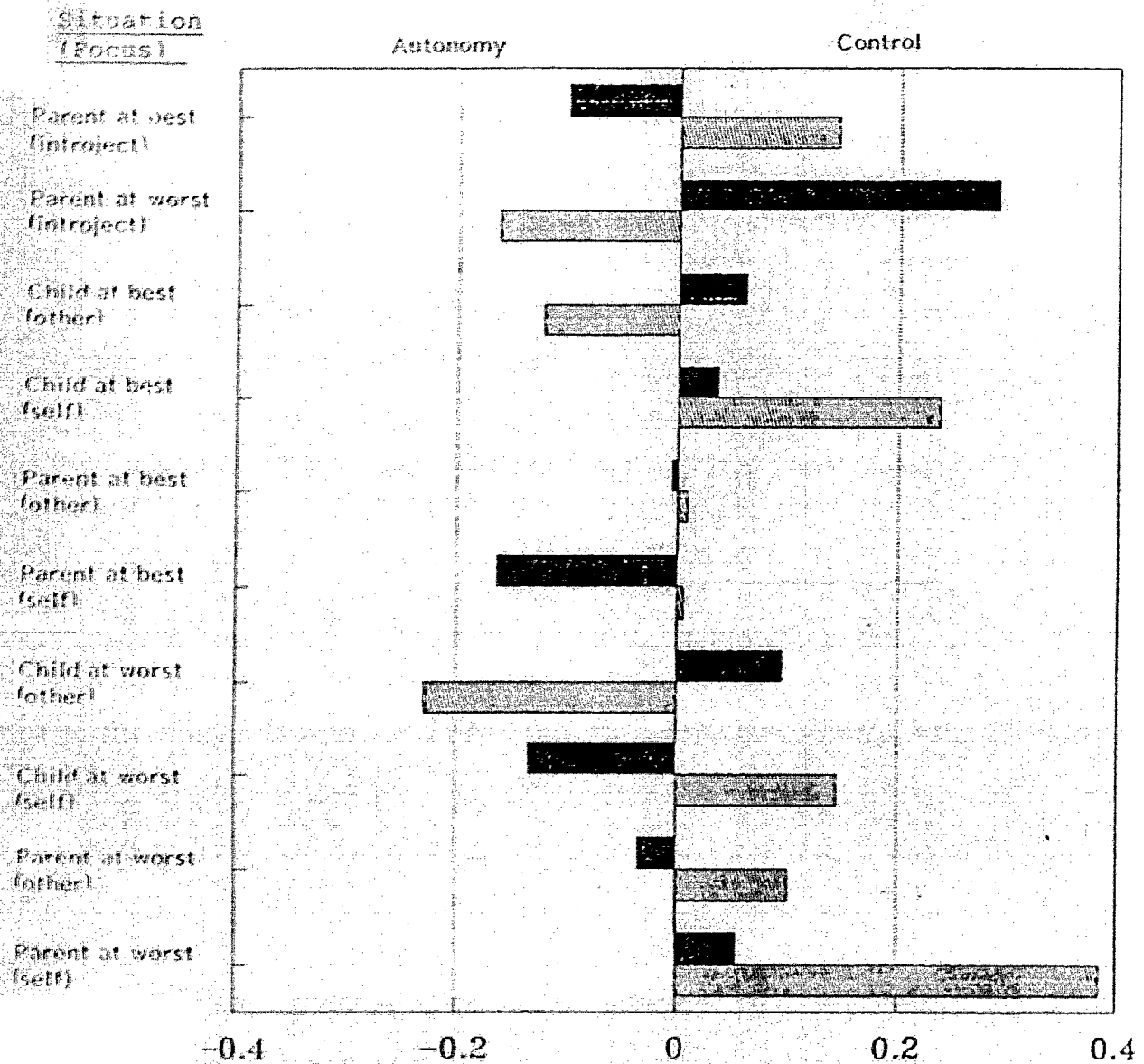
## Friendliness-Attack



**Note:** The scale above shows the direction of change from pretest to posttest. Maximum change would be represented by the number two.

# Figure 5

## Give Autonomy-Control



SD
  RPC

**Note:** The scale above shows the direction of change from pretest to posttest. Maximum change would be represented by the number two.

the friendliness pole indicates that the rater sees the child's behavior towards the parent as completely corresponding to the model's conception of loving or friendly behavior.

In Figure 4, the Friendliness-Attack axis, negative numbers indicate a change (based on differences in means between pretest and posttest) towards being more friendly when the focus is other or self and towards self-love for an introject focus. Positive numbers represent a change towards being more hostile when the focus is other, towards protesting and withdrawing when the focus is self and towards negative feeling about the self when the focus is introject. For example, a change in a negative direction on the Friendliness-Attack axis for the child at best (other focus) situation shows that the children are seen as behaving in a more friendly way towards their parents.

Improvement (moving towards the Friendliness pole) was predicted for the SD group on the Friendliness-Attack axis as follows: for both introject situations and all 4 situations where the parent was rated in relation to the child. These predictions were made due to parent's greater involvement in helping to manage their children's school attendance problem. However, it was unclear if parents' perceptions of their children would change and therefore predictions were not made for situations where the child was rated.

The changes for the SD group were in the predicted direction in four of the six situations where parents were rated on the Friendliness-Attack axis. The parents in the SD group appear to have felt that their behavior towards their children-- parent "at best" (other focus) and parent "at worst" (other and self focuses)-- was more friendly at posttest than at pretest; they also felt better about themselves (introject, "at best"). Contrary to expectations, for the introject "at worst" and parent "at best" (self focus) situations, the parents moved towards greater hostility. All four of the situations where the children in the SD group were rated shifted towards the parents feeling that the children were more hostile towards them.

For the RPC group on the Friendliness-Attack axis it was predicted that giving a positive connotation to the child's behavior would result in movement towards the Friendliness pole for all the situations where the child was rated and particularly for the situations where the focus was other (how the child was seen to be acting towards the parent). Also, as a result of positively connoting the child's behavior it was expected that the parents would have a better feeling about themselves as indicated by the introject focus. Parents were also expected to endorse a more friendly feeling towards their children for the four situations where the parent was



rated in relation to the child. Thus, a shift towards the Friendliness pole was expected for all ten situations.

Six situations changed towards the Friendliness pole in the RPC condition with one remaining about the same. Both parent and child situations were involved. The parents, as predicted, moved towards feeling more self-love (introject "at best" and "at worst"). They also rated themselves as behaving in a more positive ways towards their children (parent "at best", other focus) and as feeling they were getting more love or friendliness from their children (parent "at best", self focus). Only the parent "at worst" (other focus) situation changed towards more hostility. In the situations where the child was rated, the predicted changes were partially realized: the children in the RPC group were seen to change towards behaving in a more friendly or loving way towards their parents (child "at best" other focus) and for the child "at worst" (self focus) situation they were seen as reacting to parental direction with more friendliness. However, contrary to expectations, the child "at best" (self focus) situation moved towards the Attack pole indicating that the children were rated as having a negative feeling about themselves in the relationship. Also, contrary to expectations, the child "at worst" (other focus) showed a change towards parents feeling more hostility was being shown by their children towards them.

The direction of change for the two groups was opposite in five of the situations. The RPC group changed towards the Friendliness pole in four of these five situations. In the introject "at worst" situation, SD group parents, contrary to expectations, changed towards a more negative feeling about themselves. The RPC group changed towards a feeling of self-love for the introject "at worst" situation. The SD group for the child "at best" (other focused) situation shifted towards a more hostile or attacking attitude. In contrast, the RPC group children were rated as being more friendly. With the parent "at best" (self focus) situation the SD parents saw themselves as protesting or withdrawing from their children while the RPC parents indicated a passive sense of friendly well being towards their children. In the child "at worst" (self focus) situation the SD group rated their children as protesting and withdrawing while the RPC group rated their children as having a friendly sense of well being. And finally, with the parent "at worst" (other focus) situation the SD parents shifted towards more friendliness while the RPC parents perceived themselves to be more hostile.

In summary, the RPC group changed more towards the Friendliness pole than the SD group did. Especially noteworthy is the fact that the RPC group, in situations where the two groups changed in opposite directions, changed towards more friendliness in four of the five

situations. However, the predicted changes towards more friendliness in situations where the child was rated for the RPC group only materialized for two of the four situations. The predicted improvements for the SD group for situations involving the parents were correct in four of the six situations where the parent was rated.

The Give Autonomy-Control axis (see Figure 5) results were also based on differences in means. Positive numbers indicate a change towards being more controlling when the focus is other, towards submission when the focus is self and towards self-restraint when the focus is introject. Negative numbers indicate change towards giving autonomy when the focus is other, towards taking autonomy when the focus is self and towards freeing the self when the focus is introject. For example, a change in the direction of positive numbers on the Give Autonomy axis for the child "at best" (other focus) situation indicates that the child is perceived to be acting in a more controlling way towards his/her parents.

The parents in the SD group were predicted to move in the direction of taking more control of their children (other focus) for both the parent "at best" and "at worst" situations due to the involvement of the parents in managing the problem. Predictions were not made concerning how the children would be seen to react. It was also uncertain how the introject situations would be affected by the SD treatment.

The predicted change towards the SD parents taking more control did not occur in either of the two parent (other focus) situations. Instead, the shift was towards giving more autonomy to the children. In the introject "at best" situation the SD parents changed towards the autonomy pole indicating that they felt more free. For the introject "at worst" situation they moved towards the control pole indicating an increased sense of self-restraint. The child "at best" (other focus) situation shifted towards the control pole-- the children were seen as more controlling in their actions towards the parent. The child "at best" (self focus) situation also moved towards the control pole which indicates the children were seen by their parents as more submissive. The parent "at best" (self focus) situation changed towards the autonomy pole which suggests that the parents were taking more autonomy for themselves. The child "at worst" (other focus) situation moved towards the control pole which means that the child tended to be more controlling towards the parent. The child "at worst" (self focus) situation moved towards the autonomy pole-- the children took more autonomy for themselves. In the parent "at worst" (other focus) situation, the shift was to the autonomy pole: the parents gave more autonomy to their children. The parent "at worst" (self focus) situation moved towards the control pole indicating that the parents felt that they were reacting to their children by giving in to them.

Children in the RPC group were expected to give more autonomy to their parents rather than to be controlling towards their parents. Reframing the child's behaviors would include a relabelling of controlling or manipulative behaviors so that they would be seen as more benign. As a result of giving positive meaning to the children's controlling behaviors (for example, reframing what had appeared to be a controlling behavior as a request for help from the child), it was expected that the children would be more able to accept controlling behaviors from their parents. Thus, the parents would be more likely to exhibit such controlling behaviors.

Both the child "at best" and "at worst" (both other focus) situations confirmed the prediction that the children in the RPC group would shift towards giving more autonomy to their parents. The child "at best" and "worst" (both self focus) situations shifted towards the increased control: the children were more submissive towards their parents. The prediction that parents would feel more able to take control was also confirmed by the parent "at best" and "worst" (both other focus) situations. However, the self focus situations for the parent "at best" and "worst" situations also moved towards the control pole which means that the parents felt themselves to be giving in to their children's demands. The introject situations showed that the parents felt they were being self-restrained ("at best" situation) and were

Table 6  
Analysis of Variance for the Subscales of the Working Alliance Inventory (n= 19)

Task Scale

<u>Effects</u>	<u>MS</u>	<u>DF</u>	<u>F</u>	<u>P</u>
Treatment	122.134	1	1.454	.244
Residual	83.980	17		
Total	86.099	18		

Goal Scale

<u>Effects</u>	<u>MS</u>	<u>DF</u>	<u>F</u>	<u>P</u>
Treatment	34.816	1	.767	.393
Residual	45.370	17		
Total	44.784	18		

Bond Scale

<u>Effects</u>	<u>MS</u>	<u>DF</u>	<u>F</u>	<u>P</u>
Treatment	.022	1	.000	.995
Residual	66.892	17		
Total	63.175	18		

able to have a sense of freeing themselves ("at worst" situation).

It is noteworthy that the children in the SD group were rated as changing towards taking more control for themselves in relation to their parents on the Give Autonomy-Control axis. In contrast, the children in the RPC group changed towards giving more autonomy to their parents.

The mean subscale scores on the WAI for the SD treatment were: on the Task scale 70.78 (SD= 7.7), on the Goal scale 71.11 (SD= 6.2) and on the Bond scale 71.22 (SD= 8.1). The mean subscale scores for the RPC group were: on the Task scale 65.70 (SD= 10.3), on the Goal scale 68.40 (SD= 7.2) and on the Bond Scale 71.20 (SD= 8.2). An analysis of variance using an ANOVA (see Table 6) yielded no significant differences between the two treatment conditions on any of the three subscales ( $p > .05$ ).

In summary, the results for the first research question which concerned the efficacy of the treatments with school refusers (measured by attendance, the CBC and RCMAS) were as expected. In terms of the second research question which hypothesized that the two treatments would produce different patterns of results on the measures concerned with the parents thinking about the school refusal, about their children and about themselves (CDSCR

and SASB), the results tended to confirm that the treatments would produce different outcomes.



## Chapter V

### Discussion

This is the first study to compare systematic desensitization (SD) with reframing with positive connotation (RPC) for efficacy and differential impact on school refusers. The outcomes for treatment efficacy (school attendance, CBC and RCMAS) did not clearly show one treatment to be more efficacious than the other. However, much of the findings gave tentative support for the hypothesis that these treatments would have a differential impact. The outcomes obtained for the SASB and the CDSCR were not significant ( $p < .05$ ). Therefore, suggestive trends rather than significant findings are discussed with the emphasis on how the two treatments differed. The outcomes for each treatment are briefly reviewed followed by a comparison of the differing patterns of impact. The chapter concludes with a discussion of client management problems, clinical implications of the findings and recommendations for future research.

### Main Findings

Improvement in the children's level of anxiety was the outcome most anticipated for the SD group since anxiety reduction was the main thrust of this treatment. However, part of the observed changes in anxiety may be attributable to the fact that there is a tendency for scores which vary greatly from the mean at a given test time to more closely approximate the mean at a second testing. This is

"regression to the mean" (Harris, 1986). The mean obtained for the SD group at pretest was much higher than the standardized mean (Reynolds, et al., 1985) and therefore the opportunity for reducing the mean was maximized. However, a reduction in children's behavior problems as perceived by parents and improvements in the children's school attendance give credibility to the possibility that the SD treatment produced at least some of the observed changes in children's anxiety level. Nevertheless, what proportion of the observed changes are the result of "regression to the mean" and what proportion to the impact of the SD treatment cannot yet be determined.

Parents receiving the SD treatment appear to have felt they had less control over their children. Instead of increasing their control parents gave more autonomy to their children. Nevertheless, these parents tended to attribute more blame for the problem to their children. Parents also thought their children were taking more control. Despite the feeling of having less control and more responsibility, parents in the SD group rated themselves as feeling better about themselves and their children for some situations. But concomitant with these positive feelings was the SD parents' shift towards evaluating their children as less friendly towards them.

The RPC treatment shows a different pattern. These parents moved towards having a greater sense of self-restraint. There was some reduction in the tendency to

assign blame for causing the problem. The problem was also seen as less selfishly motivated by parents or children. The parents appeared to feel they had more control over their children. For some situations, parents felt an increased sense of congeniality towards their children. Parents also tended to feel that this more friendly feeling was reciprocated by their children.

The RPC parents' shift towards having an increased sense of control over their children was accompanied by a parental perception of their children as more compliant. Parents indicated that they felt their children were allowing them greater autonomy and were reacting to them with more submissiveness. Thus, the parents appear to have felt freer to act as they saw fit and felt that the children were more accepting of their authority.

Parents in the RPC group also rated their children as having fewer behavior problems. The apparent reduction in children's behavior problems and improvements in the children's school attendance lend credibility to the possibility that changes took place in parents' thinking about the problem.

#### Differential Impact of the Treatments

Although the treatments did not differ in how they affected the child's attendance and parents' rating of the child's behavior problems, they did differ in the degree to which each reduced the children's anxiety. Anxiety was reduced for the SD group but not for the RPC group. The

emphasis of the SD treatment was on anxiety reduction. Thus, the treatment seems to have had an impact on clients as intended. The RPC treatment did not pay particular attention to anxiety reduction and not surprisingly, anxiety was not reduced.

There was a differential outcome in parental perceptions of where the responsibility for the school refusal lay. In the SD treatment the problem was explained as a non-adaptive response to the environment and thus environmental factors were emphasized by these parents more following treatment. SD parents also shifted to feeling they were more responsible for the problem than their children. These parents had been given tasks to help their children reduce their anxiety. This increased parental role may have led to the perception that parents could be more responsible rather than blaming their children for the school attendance problem.

In contrast, the RPC parents tended to take more responsibility for the problem rather than blaming circumstances. During the RPC treatment the counsellors attempted to change how the parents thought about their child's problem. This shift in thinking was meant to increase parental responsibility for and control over the problem by framing it as having a benign intent. This shift in understanding of the problem was expected to lead to parents feeling less threatened or challenged by their children. Thus, it should have been easier for parents to

engage the problem and gain a greater sense of control and responsibility over it. However, RPC parents indicated that they saw the children as more responsible for the problem than themselves. The child focus of the treatment may have contributed to this effect. The students, however, do not appear to be blamed by parents since parents indicated that the problem was not selfishly or intentionally caused.

The SD and RPC treatments shifted in opposite directions in terms of how changeable parents thought the problem was. This may be the result of the SD treatment emphasizing specific tasks while the RPC treatment emphasized more acceptance of the child's actions. However, despite the indication that things were not changeable by the RPC parents, there was evidence in the measures of efficacy and the process measures that things had tended to change. For example, the ratings of the children's behavior problems improved, there was a tendency for school attendance to improve and there were shifts in the child-parent relationship measures.

The issue of parental authority is an important one. A lack of parental authority could create the conditions for the child to refuse to attend school. The RPC treatment was designed to influence relations between parents and their children and was expected to shift control to parents. The SD treatment was not directed primarily at child-parent relations. It was designed to

have parents teach the children a method of relaxation. Parental authority did increase for the RPC group but not for the SD group. As well, parents in the RPC group felt their children were willing to accept this authority. Parents in the SD group felt their children were less willing to accept their authority.

These differences in perception of authority in the parent-child relationship also appear to be related to differences in the two treatments. Parents in the SD treatment were to teach their children a particular method of relaxation: the parents' role was to deliver information; the child's role was to receive it. The information flowed from parents to children in pre-determined steps. This unidirectional flow of information may have made it more difficult for the children to accept the new role the parents had been given or it may be that it was the parents who could not accept their role as teachers.

With the RPC treatment, the focus was on process rather than content. The attention of parents was directed to the positive aspects of the child's behavior towards the parents. The parent-child relationship was construed as circular: how the parent behaved towards the child would influence how the child behaved towards the parent. Thus, changing how the parent thought about the child ought to have created an atmosphere which would have been conducive to the child's behavior improving.

Although the SD treatment was not primarily aimed at changing child-parent relations, it nevertheless appeared to. Some of the changes were positive, such as parents' rating themselves as being more congenial in relations with their children. However, the SD group parents rated their children as more hostile towards them for all four situations where this was possible. Perhaps these parents were uncomfortable with the role of teacher and therefore perceived their children to be more hostile. It could also be that the children were actually more hostile as a result of being identified as the ones who had the problem (anxiety). It was the children who were being asked to change. However, even if the hostility existed only in the minds of the parents, such perceived hostility on the part of the children could have serious negative consequences in the future of the parent-child relationship.

The RPC group parents also indicated some increased hostility on the part of their children. RPC parents may have felt that their increased control over their children would be received by the children with hostility, at least when the children were at their worst. However, they also rated their children, to a greater extent than the SD parents did, as being more friendly. The RPC treatment was expected to result in a more positive feeling towards the children by parents and this, in turn, should have made it easier for the children to be more friendly towards their parents.

In conclusion, the SD method has maintained its credibility as a treatment of anxiety and the RPC method has shown that it has an equal potential for working with school refusers. It also appears that some outcomes were produced specific to each treatment.

#### Client Management

As the literature review (Chapter II) suggests, only one trait is common to all school refusers: they avoid school. This avoidance is often accompanied by some fear or anxiety concerning school. Also, there is a tendency to prefer staying at home. School refusers' predilection for avoidance makes them a difficult group to work with. Counselling these clients at school is often not practical. However, going to the family home, as we often did in this study, created other problems. Some parents of students referred to this project were transient. A few could not be reached to complete data collection. The counsellor was put in the role of pursuer. Pursuing the clients may have contributed to some not completing the counselling. Also, many counselling sessions needed to be re-scheduled due to participants failing to keep appointments. A lack of parental commitment to a schedule connects children's avoidance of a school routine to their family context: a lack of order in the family may lead to school organization seeming alien to these children. The inability to follow an organized routine was also suggested by the failure of some clients to do their homework assignments.



The children in this study appear to fit the descriptions of school refusers in the literature: issues of attachment to a parent seemed more common with primary aged children while older children appeared to have more difficulty with peers. However, most were capable students. Several children were clearly quite anxious while some appeared withdrawn and depressed. Others appeared to be neither anxious nor depressed but merely preferred to stay at home and experienced unpleasant feelings only at the time of separation from their mother. The relationship between parents and the children seemed to be systemic in some cases. For example, some were unemployed single parents who appeared to have little social life and seemed to enjoy the companionship of their children. Also, some children seemed to enjoy a very close and mutually rewarding relationship with their parent(s). These children, while at school, seemed unable to get the sort of attention to which they were accustomed. It was the goal of the RPC treatment to alter perceptions of the parent-child relationship so that such systemic factors were also altered.

#### Clinical Implications of the Findings

The SD treatment would be most obviously useful when the child's anxiety is the salient feature of the school refusal problem. There were, however, some children who received the SD treatment who did not have a pronounced anxiety. When anxiety was not a salient feature of the

school refusal, then the SD treatment seemed more difficult to implement. Also, there were some clients who seemed resistant to following the directions for practicing the relaxation. Others appeared to be distracted by alternative explanations to the rationale given. The inadequacies of the school system or an unfriendly peer group were stressed by some. Thus, a willingness to accept the rationale for treatment and to follow counsellor directions appears to be needed.

Parents in the SD group felt that their authority was diminished and that their children were more hostile towards them. Since parents in the SD group were asked to take the role of a teacher with their children, it is possible that this was responsible for these negative outcomes. Also, since the SD treatment depends upon cooperation from the children in practicing relaxation, it may be that someone who was perceived as authoritative by the children should be conducting the practice sessions. Parents might not have had the required authority with their children even before treatment. Perhaps the apparent negative parent-child relationship outcomes could have been avoided if parents had not been involved as teachers in the treatment. However, since someone outside the family would not have the same access to the children as parents, it would probably require more than four sessions to provide sufficient training for children.

However, since anxiety is frequently a salient feature of the school refusal problem, SD does appear to have a place among the treatments for school refusal. SD did not produce significant improvement in the children's school attendance. There might have been better results if the counsellor was allowed to choose which cases received the treatment.

The RPC treatment was as efficacious as the SD treatment, except for anxiety reduction. Therefore, if it seemed to a counsellor that anxiety reduction was necessary, RPC may be counterindicated. However, the tendency for the RPC treatment to lead to parents feeling increased control over their children and seeing their children as more accepting of this control strongly recommends the treatment. More authoritative parents who feel their children are more compliant ought to find it easier to send their children to school. Generating more friendly relations between parent and child seems worthwhile in itself. More authoritative parents and more friendly parent-child relations may also help to create an atmosphere in the family which would be conducive to solving a variety of problems in addition to helping with the school refusal.

There were some undesirable outcomes with the RPC treatment. The children were perceived to be more hostile towards parents for some situations. It is possible that too much attention was directed to the behavior of the

children. The RPC treatment was to have emphasized the relationship between parents and children. However, the children's side of the relationship was probably emphasized more in practice. It may have been preferable if more time had been spent discussing how the parents reacted to the children. As much effort could have been put into positively reframing the parents' actions towards the children as was put into reframing the children's actions.

It is important with the RPC treatment that the reframes fit the family situation. Fitting the reframe to the family's perception of reality allows for considerable flexibility in implementing the procedure since the particularities of the family situation, including their beliefs and attitudes about the problem, are taken into account. However, the necessity of adapting the reframe to the client's situation requires skillfulness and judgement on the part of the counsellor which may be difficult to acquire without experience. Thus, although the RPC treatment is quite adaptable, it may take considerable time and forethought to plan appropriate reframes. Nevertheless, the tendency for the RPC group to improve in children's attendance and to show improvements in parent-child relations suggests that this method may have potential for use with school refusers.

#### Limitations to the Research

An important limitation to this study was the lack of a "no treatment" control group in its design. The absence

of such a control makes it more difficult to rule out some threats to the internal validity of the study (Harris, 1986). These threats include the possibility that the changes observed could have been caused by contact with a counsellor (the Hawthorne effect), regression to the mean, or a process of maturation. Thus the outcomes obtained may have been the result of factors other than two treatments.

The findings in this study are also limited by the scale of the investigation: there were only 19 cases; 10 in the SD group and nine in the RPC group. The findings ought, then, to be taken as suggestive rather than as conclusive. The experimental outcomes, however, can form the basis for hypotheses to be examined through future research.

#### Recommendations for Future Research

The trends (described above) concerning attributions, parent-child relationship factors suggest that the treatments produced outcomes which were specific to the treatments. Such treatment specific outcomes as the tendency of the SD group to shift responsibility for the school refusal to environmental factors, to attach blame to those who were seen to cause the problem, for parents to feel their authority was reduced and to feel that their children were more hostile, need to be tested in further research. Also, it has been suggested above that parents in the SD group may have been uncomfortable with the role of teacher. This would be important to confirm or

disconfirm in future research since the decision to include or exclude parents may depend on whether or not they are useful in the role of teacher with their children. Such undesirable outcomes for the SD treatment are particularly important since such "side effects" to the treatment have not been previously reported in the literature.

A quite different pattern of change was obtained for the RPC group. The parents perceived themselves to have increased their control of their children while the children were seen to be more accepting of their parents authority. The parents' tendency towards assigning less blame for the problem, the perception that the children were less hostile, improvements in friendliness between parents and children and other such shifts are outcomes which are important in determining the usefulness of the RPC treatment. Therefore, these outcomes need to be replicated in future research if they are to be accepted as outcomes which may be expected with school refusers. It is also important to determine if changes in how the RPC treatment was implemented would result in a different pattern of outcomes. For example, would including parents to a greater degree in the reframe change the pattern of outcomes?

In conclusion, the findings of this study are suggestive. Conclusive proof of the efficacy of the treatments is not offered. Nevertheless, the tentative findings of this study represent a beginning attempt at

addressing some gaps in the school refusal literature. The finding that the RPC treatment was as efficacious as the SD treatment is an addition to what is known about strategic techniques for use with school refusers. The possibility that the two treatments may have a differential impact on clients is an important possibility. Knowledge of a variety of ways that a treatment may influence those identified as having a problem and their families could be very useful for counsellors. For the SD treatment, where the focus of the treatment is somewhat circumscribed (reducing anxiety), considering how the treatment may affect variables other than anxiety is often neglected. Nevertheless, the SD treatment may produce outcomes in addition to those targeted which could be of importance to counsellors who may wish to use this method. Alterations in family relationship variables and in parental thinking which appear to have occurred as a result of the RPC treatment suggest that this strategic method may have a place among the treatments used with school refusers.

Appendix A  
Manual for Using Systematic  
Desensitization with School Refusers



Counselling Steps:Session 1

- 1) Exploring the problem and establishing rapport.
- 2) Rationale for systematic desensitization.
- 3) Visualization assessment and homework assignment.

Session 2

- 4) Continue assessment
- 5) Begin teaching relaxation.
- 6) Develop a hierarchy.

Session 3

- 7) Discuss in vivo progress through the hierarchy.
- 8) Have a parent conduct a relaxation exercise.
- 9) Teach a brief relaxation method.
- 10) Attempt the next step in the hierarchy.

Parental Management

- 11) Practicing relaxation response.
- 12) Continue progress through the hierarchy.

Between Sessions Phone Contact

- 13) Discuss any problems that have occurred.

Session 4

- 14) Review of work so far with emphasis on applying what has been learned.
- 15) Termination.

### First Session

The goal of the initial session is to learn about the problem from the point of view of the child and to begin to develop rapport with him/her. In gathering information about the problem and its history it will be important to explore events leading up to the school refusal episode even if they were a long time ago. Once the information gathering phase has been completed and the counsellor has "joined" with the client in order to build rapport, presentation of a rationale to give the client an overview of what is to come in the counselling will take place. The next step involves the counsellor conducting an assessment of the child's visualizing ability. The session concludes with a summary of and the assignment of homework.

### Counsellor Stance

The work that the counsellor is to do is conceived in psycho-educational terms: a large part of the intervention will involve teaching the parents the techniques of desensitization. Thus the counsellor stance will be that of a teacher conveying information-- albeit information directed at dealing with their problem. The counsellor will be taking a problem solving stance: he/she will not be seeking information about causes of problems so much as trying to find out how problems function as part of the client's lives currently and then presenting a way of

dealing with the problem directly.

#### Joining to establish rapport

It is necessary for the counsellor to establish rapport with both the child and his parent. Also, since the child may not feel comfortable discussing his/her feelings about school, it would be useful to meet for 15 or 20 minutes with the child without the parent(s) being present. The child would be asked if there were any things said in the private interview which he/she does not want shared with the parent(s). When the parents rejoin the session they should be given a review of what the child has said and at the same time be assured that it can be dealt with. The parents should then be asked for their comments and views about the problem. The counsellor should:

- make statements which affirm the positions/situations of the child and his/her parents.
- speak in the language used by both the child and his/her parents, and should recognize their concerns and comment on them in a non-judgemental way.

#### Examples:

Mother: I don't have any time to myself with Junior always at home. Yet I know how long and tiresome the day can be if I have to spend it by myself.

Counsellor: It's very hard to balance getting enough time for yourself with your need for company.

Child: Kids laugh at me at school and it makes me feel like a jerk.

Counsellor: I don't think anyone would like being laughed at or feeling like a jerk.

### Conceptualizing the Problem

How both the child and parents conceptualize the problem will have a great impact on whether or not they feel able to begin to manage it and on how they feel about desensitization as a method for coping with this problem. The counsellor's goal is to help them accept a model of the problem which involves seeing it: 1) as a non-coping way of responding to environmental stimuli, 2) as a learning problem rather than a problem of character, and 3) as something which they can learn to manage on their own. Some of these issues can be dealt with when the counsellor gives the rationale for the desensitization intervention. However, while listening to the child or the parent tell about the problem the counsellor may need to begin building a conceptualization of the problem which will be more likely to lend itself to being dealt with through desensitization.

#### Examples:

Child: I don't usually mind school. But sometimes the teacher picks on me and then I wish I wasn't there. I can't do anything about it when the teacher is mean.

Counsellor: It's true you can't control the teacher. But you can learn to control how you feel when the teacher does something you don't like. I want to teach you how to make school feel better.

Mother: I just don't see how I can make Junior go to school when he says he isn't feeling well. I'm not a strong enough person to force him even if I think it might be the best thing to do.

Counsellor: It's hard to know what is best to do especially when your faced with Junior who is suffering. But the problem may be that Junior has learned how to deal with his negative feelings about school by staying away. He'll suffer much less when we teach him how to manage the discomfort he feels while he is at school.

In a situation where the child appears to not be highly anxious about something at school but rather prefers to stay home to meet needs for nurturance or just to avoid the pressures of school by extending illnesses beyond the time needed to recover and by feigning illnesses on occasion, the counsellor may say something like the following:

Counsellor: Part of growing up is learning to deal with situations that we don't much like. Learning to feel more comfortable, more relaxed in these situations makes it easier for us to pay attention to the jobs we are supposed

to do. When we do better at the jobs the situations become less uncomfortable, less tense.

### Rationale for Desensitization

It is important to note that the language used in the rationale may be varied to suit particulars of the case. The following explanation will be presented to the child and the parent(s) by the counsellor:

Counsellor to the child: Often people run into situations that make them uncomfortable, nervous or afraid. When people feel this way they often want to avoid the situation. Sometimes being afraid or uncomfortable can be good. For example, being afraid or uncomfortable about fire or busy streets or being picked on by a bully can help to protect you. But other times being uncomfortable or afraid keeps you from doing things which you should be doing. I am going to teach your mother (or father or parents) how to teach you a way to learn to feel less uncomfortable when that is what you want to do.

Do you know what tension is? Squeeze your fist very tight. Feel how tight the muscles are. This is tension. Sometimes we are tense and don't even know it. Now let your fist go. This is relaxation. Did you know that it is not possible to be tense and relaxed at the same time? Another example is this elastic band. Notice when you pull on the elastic the shape changes and the elastic feels different-- it feels tighter. That's how our

muscles feel when we are not comfortable or when we are nervous. I am going to teach you how to relax and your parents are going to learn how to do this too so they can help you practice relaxing. When you've learned how to do this we'll show you how to do it in places that make you feel uncomfortable or tense. But we won't ask you to try and relax in the places that make you feel most uncomfortable right away: you'll practice with easier situations first.

Counsellor to the parent: As you've just heard, your help in practicing the relaxation exercise will be needed. So its important that you learn how to do the relaxation exercise so that you can do it with your child. Your child's difficulties may be a result of becoming tense near or in school. She (he) is trying to avoid this tense feeling that is associated with school. I will be teaching you and your child a method that will assist you to control tenseness in progressively more difficult situations. The best way to avoid being tense is by being relaxed. If you can make yourself relaxed at will then you can "turn your relaxation on" in situations that make you tense. Also, later on your child (use name) will need to practice relaxing in real life situations. I will start working with him/her and you will work with me to learn how to teach him/her this method. Your help is much needed and will aid a great deal in your child's successful learning of this method.

### Assessment of Visualizing Potentials

Some children have difficulty visualizing scenes and therefore are unsuitable for interventions wholly dependent on visualization. Other children have difficulty learning how to relax. Some exploration of these factors needs to be conducted with the child before deciding on a particular version of desensitization.

Imagery assessment can be something like the following:

Counsellor: People use their imaginations differently, so I'd like to see how you use yours. Sit back and relax a brief breathing exercise can be used here). Now get a picture in your mind of a summer scene at the beach.

(Pause) Describe the scene you imagined.

Child: It was hot and there was sand and palm trees.

Counsellor: Uh-huh-- it was warm and felt the sandy. What colors besides the green in the palms did you notice?

Child: The trees were green and the ocean and sky were blue. The sand was white. The sun is yellow.

Counsellor: Are able to hear anything?

Child: I didn't hear anything.

Counsellor: Keep imagining your scene and try to hear something.

Child: I can hear waves.

Following this the counsellor can ask the child to imagine a scene that he/she mentioned when being asked about school. The counsellor will need to find out if the



uncomfortableness or anxiety can be reproduced by the child by imagining the scene. The counsellor will ask the child to describe what he/she is feeling and observe the child for overt signs of tension (body twitches, tapping feet, shakey voice and so on).

A judgement call will need to be made by the counsellor concerning the child's imaging ability. If the child reports that he/she cannot produce the requested scenes and continues to have difficulties even when prompted by the counsellor, then alternatives will need to be considered (more of this below). If the child has some difficulty but is able to visualize the scenes when prompted to the degree where they report feeling as they would in vivo or they show clear signs of anxiety during the visualization, then imagining scenes could be part of the intervention.

### Homework

For those children who will not be able to use imagery as part of the relaxation procedure it will be necessary to learn about when they are relaxed. For those who can visualize knowing in what situations the child relaxes will help in constructing scenes that are relaxing. Is there a favorite place, favorite toy or other object and so on, with which the child feels most relaxed? Ask the parent(s) and the child to construct a list of activities, situations, times and things which

they find pleasant or relaxing. This list should contain a minimum of 5 items.

Counsellor Activities:

- establishing an alliance
- direct questions or probes about the problem
- helping the clients to conceptualize the problem in way that are amenable to change.
- assessment of visualization ability
- summarizing or integrating information

Second Session

The goals of the second session are to continue to discuss the parent(s) and child's view of the problem, to assess the child's ability to respond to relaxation training, to begin teaching relaxation and to begin to construct a hierarchy.

If it has been determined that the child has difficulty with visualizing, then those portions of the muscle relaxation exercise involving imagery can be omitted. After a brief review of the previous session with questions as to whether or not the child or parent(s) have anything to add the relaxation method is presented.

Relaxation Exercise

The following is a combination of deep muscle relaxation, breathing exercises and imagery.

- Before beginning the exercise the child and parent(s) will need to be in a comfortable position with loose clothing and body supported. The parent(s) will be asked to participate in the relaxation exercise so that they can understand what their child is experiencing.
- Take a deep breath, breathing in slowly through your nose using your tummy to pull in the air. Hold it for the count of 5-- 2, 3, 4, 5. Let it out slowly. The air brings in relaxation and breathes out tensions.
- Close your fist squeezing as tightly as possible feeling the tension in the muscles of your hand. Hold it for a count of 5-- 2, 3, 4, 5. Now release your hand and feel the tension going out of your hand. You will feel this sense of release of tension as we tense and release muscles in other area of your body.
- Repeat fist squeezing with the other hand.
- Tense and release muscles in one foot and then the other.
- Tense and release calf muscles.
- Tense and release thigh muscles.
- Continue tensing and releasing with buttocks, abdomen, stomach, chest, upper arms, neck and face.
- Take a deep breath sending relaxation to any tense parts of your breathing out tensions.
- Relax and enjoy the heaviness of your muscles and your sense of relaxation.
- Now I would like you to picture a long, black wall

stretching into the distance. Imagine yourself walking slowly along this wall. On this wall are large, white numbers from 1 to 10. Your walking past number 1 now and continuing to feel relaxed. As you move towards number 2 you feel slightly more relaxed. Your now slowly moving past 2 towards number 3 and as you do, feel a little more relaxed still. (This is continued until reaching number 10 which is described as being very, very relaxed).

The counsellor will need to ask some questions to ascertain whether or not the child has achieved a satisfactory level of relaxation. Direct questions such as, "Did you feel different during this exercise? Tell me about how you felt? Where in your body did you feel different?" and so on would be used to assess whether or not the exercise was successful. If the child reports very little change then alternative methods of achieving a state of mind which will reciprocally inhibit the discomfort the child experiences will be used (see below).

The parents will be asked to participate in the relaxation exercise above along with their child. The procedure will be written down for parents to take with them for later practice.

#### Alternatives to Relaxation Exercises

If the child does not respond to the above relaxation exercise, then the counsellor may turn to the list of

things with pleasant associations that was made for homework to find a substitute for the relaxation exercise. Food has been used to inhibit anxiety as well as objects which might have special meaning for the child such as toy. In some cases, where the child can visualize adequately but has trouble achieving relaxation with the exercise used above, an image that is relaxing because of the personal associations the child has with it could be used (perhaps even photograph of a parent). If some object or image is used it would be helpful to have the child practice some breathing and focusing such as the following:

Counsellor: Take a deep breath, breathing in through your nose. Hold it for a count of 5-- 5,4,3,2,1. Feel the relaxation going through your body as the air goes through your body. (Repeat the breathing a second time). Focus your mind on (name object or image) and feel the relaxation in your body. I want you to stay focused on this for a few seconds more.

#### Constructing a Hierarchy

Since what causes anxiety is likely to vary greatly from client to client, it is important that the hierarchy reflect the particular experience of the child. There are five criteria for constructing an adequate hierarchy: 1) items should represent situations that are under the client's control, 2) items should be concrete and specific

(ie., should be able to clearly and vividly visualize the item), 3) should represent as nearly as possible actual situations the client is in, 4) should reflect as broad a range of situations that anxiety occurs in as possible, 5) should reflect a range of emotions from low to high intensity. In addition, since it is assumed that the anxiety is related to the school situation, in most cases the hierarchy will have items that progress from where there is little proximity to the school in space or time to items that have the client in the classroom situation experiencing a situation that is at the highest level of discomfort for him/her. The hierarchy will be between 5 and 10 items long depending on the age of the child and his/her ability to make such a list.

The counsellor will review the list of pleasant situations done for homework (if this has not already been done to find alternative methods of relaxing). The child will be introduced to the idea of ranking the items by having him/her rank the list of pleasant items from most to least pleasant. Once the child has grasped the idea of ranking the discussion can be turned to the child's difficulty with school attendance. The counsellor would continue joining with the child while working on these lists by using his/her language and by showing interest in things that interest the child such as, cartoons on t.v. or the newspapers.

Examples:

Hierarchy (for a younger child)

- 1) You feel sad as you walk to school by yourself.
- 2) The teacher looks angry as you take your seat.
- 3) The teacher says you must do some work that you find hard.
- 4) You begin to feel ill and ask to go home.

Hierarchy (for an older child)

- 1) You wake up Monday morning and realize that your supposed to get ready for school and begin to feel an upset stomach.
- 2) You are in the classroom with only the teacher and she is helping you do work that is familiar and easy for you.
- 3) You're waiting at the bus stop to be taken to school.
- 4) You are in the classroom with just the teacher and she is helping you with a problem you have some difficulty with.
- 5) You are asked to go in front of the class to work a problem that you don't understand at the blackboard.
- 6) The teacher makes a negative comment about your work and the other children laugh at you.

The child will be asked, once it is determined that he/she is able to achieve a relaxed state, to go through the hierarchy items in vivo. The parents will need to supervise the progress through the hierarchy. Therefore, some of the practice may need to be done outside of school

hours. For example, it may not be practical or desirable for the parent to accompany the child to class and take the bus with him/her and so on. But in the evening or after school the parent could go with the child to the bus stop or to the classroom. Role playing the anxiety producing situations in the classroom may help in some cases. If the child is to try facing the hierarchy situations alone permission to withdraw should the child begin to feel overwhelmed will need to be arranged with the classroom teacher.

#### Homework

The session will conclude with a review of the relaxation method and of the hierarchy. The parent will be asked ensure that the child begins to go through the first two items of the hierarchy while practicing the relaxation. They will be given a log to record their experiences for discussion during the next session.

#### Counsellor Activities

- assess the ability to relax and settle on a suitable relaxation method.
- ensure that there are a sufficient number of items in the hierarchy and that criteria for concreteness, controllability, range of emotions and relevance to the client's situation are met.
- use probes to gain the necessary information.



### Session 3

Session 3 will be primarily concerned with continuing to teach the parents to implement the desensitization procedure. The session will begin with a discussion of the homework assignment and any problems which arose from that. A parent will be asked to conduct a relaxation exercise. Next, the parent(s) and the child will be taught how to shorten the relaxation instruction to make it more practical in actual situations that the child will encounter. This session should take place, if at all possible, in a location that allows the child to be exposed to the next hierarchy item. The session would conclude with a debriefing of the exposure to the hierarchy item and the assignment of homework.

#### Brief Relaxation Instruction

A brief version of the relaxation is needed so that the child can re-create the relaxation response him/herself in vivo without going through a full blown relaxation procedure. The long, black wall with numbers on it can be used to cue the child to a particular level of relaxation, presuming they are using imagery. If some concrete object is being used the child can handle it and take a couple of deep breaths as instructed above.

#### Example:

Counsellor: Now that you've learned how to relax yourself I'm going to teach you a quicker way to become relaxed.

Get comfortable. Now, take a deep breath, hold it for a couple of seconds and breath out fully. Imagine you see the long black wall. Picture yourself by the number 7 and feel yourself being as relaxed as you were during relaxation practice.

### Homework

The parents will be asked to continue working on the hierarchy and to keep recording their experiences in the log provided.

### Counsellor Activities

- discuss experiences arising from the homework
- teach the brief relaxation method.
- accompany the child and the parent as the child is exposed to the next hierarchy item.
- discuss experience with them in a way which will encourage them to continue practicing.

### Parental Management

Parents will be in charge of doing relaxation exercises with their children while they complete the hierarchy items. Contact between the parents and the counsellor will be made by telephone to ensure things are progressing satisfactorily.

### Steps to be taken by parents

- 1) Repeat hierarchy items done previously.
- 2) Introduce new hierarchy items.

3) Record experiences in the log provided.

#### Between Sessions Phone Contact

It is necessary for the counsellor to call the clients at a pre-arranged time in the week between session three and session four to ensure that they are not getting bogged down with implementing the steps required of them. The parents will be asked to refer to the log they have kept to help focus the discussion. If there are problems, then the counsellor will give instructions as to how they should be handled. Otherwise the counsellor can make supportive and encouraging comments.

#### Session Four

A final session needs to be set up to deal with any left over business or unforeseen problems that may have come up and will include a review of the work done so far. Suggestions for dealing with future problems can be made: since it is a coping model of systematic desensitization the counsellor would draw attention to how well the client's have managed. Besides supporting the work that has been done and encouraging the clients to use their new found skills, it is important to have a formal separation between counsellor and clients. Also, if other issues have come to the surface during the counselling it may be necessary to make a referral to another source.

If time allows, the child will be asked to imagine the worst possible thing that might happen to make him/her

uncomfortable with going to school. The child would then explain how he/she would cope with this situation. The session would end with the counsellor drawing attention to progress made and encouraging the feeling that the child and his/her parents will now be able to handle similar situations more effectively.

**Appendix B**

**Manual for Using Reframing with  
Positive Connotation with School Refusers**

Counselling Steps

Step 1. Defining the Problem

- a) Counsellor stance
- b) Alliance building and joining
- c) Problem exploration and problem definition

Step 2. Identifying Attempted Solutions

Step 3. Setting Goals or Definition of the Concrete Goals  
to be Achieved

Step 4. Reframing with Positive Connotation

Step 5. Follow up and Consolidation

- a) Problems accepting the reframe
- b) Phone consultation
- c) The final session

The reframing with positive connotation (RPC) treatment outlined here is intended for use with children who have refused to attend school. Reframing is defined as a fundamental altering of the meaning attributed to a situation through changing the conceptual and/or emotional context (frame) in which this situation is experienced. Thus the counsellor provides a re-labeling or a new interpretation of the problematic situation. Reframing will be coupled with the technique of positive connotation; positive connotation means that the re-labeling will provide an interpretation or definition of the situation which identifies or emphasizes positive aspects of the situation. The new way of perceiving the situation will be directed towards a whole family context or perhaps even towards the school situation rather than just reframing and positively connoting an individual's perceptions of the situation. The problem is defined as systemic.

The intervention will consist of 4 sessions: the first three sessions will be conducted on a weekly basis in three consecutive weeks followed by a telephone contact of about 15-20 minutes during the fourth week and a final meeting during the fifth week. The counselling will consist of 5 steps: 1) defining the problem, 2) identifying the attempted solutions, 3) setting goals or definition of the concrete change to be achieved, 4) reframing with positive

connotation 5) follow-up and consolidation. These steps do not necessarily coincide with the sessions but may occur during any of the sessions since the process is conceptualized as circular rather than linear.

### Step 1. Defining the Problem

#### A. Counsellor Stance

The stance or attitude that the counsellor presents him/herself with during the initial interview sets the stage. Three elements of the counselling stance are discussed here: 1) problem solving, 2) non-blaming, and 3) one-down or consultant position.

Taking a problem solving stance implies that the counsellor conveys to the client the idea that the counselling process is not directed towards uncovering causes for problems but rather seeks to find out about how the problem affects people currently. Clients need to understand that having problems is viewed by the counsellor as something which is part of the human condition. The counsellor might say to the parents something like:

Having problems is part of living. Getting stuck temporarily, not being able to find a solution to a problem is also common. Sometimes it takes consultation with someone outside of the situation to help you find out what is missing in your attempt to solve the problem. I see my role as a consultant



making suggestions to aid you in doing this rather than as someone who finds the answers or digs into your past looking for reasons why you have a problem. Sometimes it also happens that somebody's attempt to solve a problem becomes a bit of a problem itself. Like when you argue with someone, the harder you try to convince them the less they listen. But if you become agreeable, then you are listened to.

Addressing the parents in this way implies that they are in charge of the situation rather than the child.

Closely related to a problem solving stance, and perhaps implied in it, is a non-blaming stance. But since it is quite common for parents to blame themselves when their children have problems it is necessary for the counsellor to state explicitly that he/she does not blame them. Saying something to the effect that, "in our work it is assumed that no one is malicious but rather people are well intentioned and only require some new perspectives to look at", would be helpful.

Taking a "one-down" or consultant's stance will support a problem solving and non-blaming stance and also aid in alliance building. Such a stance implies allowing the client to be in the position of authority and recognizes the fact that they are in fact more "expert" at what happens in their life than you could ever be. A one-down stance does not, however, imply that the counsellor is inactive. On the contrary, the counsellor

needs to actively direct the course of counselling while at the same time avoiding an air of superiority. It will help if the counsellor "normalizes" the situation by pointing out that what the family is experiencing is what often happens, is the usual way experiencing such problems. The counsellor may mention that this could be a time of transition for the family and that to feel the way they do is "normal" under the circumstances. Thus, the family is likely to feel less threatened, less defensive about having to seek help.

#### B. Alliance Building and Joining

At this stage of the counselling the goals are: to hear about the problem from the point of view of the family members present, to arrive at a clear definition of the problem. At a minimum, one parent and the school refusing child should be present. Although not essential, the inclusion of both parents and siblings may also be of benefit. In order to facilitate the goal setting process it is necessary to build a working alliance with the family members. Each family member's point of view is referred to as their position; position includes such things as the person's attitude to the problem, opinions held about it, motivation to change and basic values. To help in assessing their position, the child and the parents should be asked in turn, "What is your best guess as to how this problem works in your family?". Joining with the client is

accomplished by affirming their position, finding areas of common interest or experience and by showing them that they have been heard (repeating parts of what they have said, adopting the client's use of language, summarizing the content of their statements and so on). Joining is the first step in alliance building; the counsellor must judge whether or not he/she has succeeded in joining by being attentive to the client's responses-- facial expressions, posture and their willingness to share private thoughts and feelings indicative of trust in the counsellor.

#### Example of Joining

Counsellor: (to child) Before we get into talking about your problem with going to school I was wondering if you would tell me about some of the things that you like to do.

Child: I've been sick so I stay home and watch t.v.

Counsellor: Oh, and what do you like to watch?

Child: Sesamee Street.

Counsellor: Do you have a favorite character?

This type activity is used to try and elicit the child's interests so that the counsellor can find some common ground with the child and so join him/her in their interest. Thus, alliance building or joining begins before getting into a discussion of the presenting problem since the child or his parents are likely to be anxious about entering counselling.

In addition to the above, alliance building and assessing positions are aided by the counsellor encouraging

that family members speak in the first person. This "speak for yourself" request allows the counsellor to assess who is troubled by the problem and who is not and helps to ensure that the counsellor is allying himself with the positions of the people involved and not supporting the collusions or agreed upon versions of the story. Making such connections with the genuine positions of the clients aids in the essential process of putting the problem into concrete terms.

#### Example of Speaking for Self

Mother: If my husband were to back me up when it comes to disciplining the kids there would be a lot less problem.

Counsellor: You may be right-- I don't know. I'd like you to tell me from your own point of view right now-- what are the situations in which you like your husband to assist you? How do let him know?

#### C. Problem Exploration and Problem Definition

After the counsellor "connects" with family members, the problem still needs to be explored more fully and defined in concrete, behavioral terms. The counsellor needs to know such things as: What are the benefits that family members accrue by having things the way they are? Who is motivated for change? The following are some questions which will help to elicit the required information:

1. How is it a problem for you?

2. How has this problem interfered with your daily life?
3. What consequences has it had for you?
4. Can you give me an example?
5. Is there a particular aspect of the problem that stands out most?
6. What is the most important difficulty for you at this particular time?
7. How would things be different if the problem disappeared?

The questions will be directed, for the most part, at the parents in order to establish the idea that they are in control and be in charge of whatever changes are made. Nevertheless, the child must be given a chance to answer similar questions when the parents have finished.

Clearly, the problem in all these cases is that a child is not going to school. However, it is important to get the parents to state the difficulty in a form that is amenable to change. Statements like, "We don't give him enough attention", or "because we love her maybe we spoil her by letting her stay home", are too vague and do not tell us precisely what is to be done to rectify the situation. How much is enough attention? Can parents stop loving their child? A statement like, "we want Johnny to stop screaming and crying when asked to get ready for school", is much more specific. The counsellor should seek have the parents express the problem in behavioral terms--

how much, how often, when things will happen, who will do them, and so on.

### Counsellor Activities

- Establishing an alliance or "joining"
- Direct questions and probes
- Summarizing and integrating information
- Exploring secondary benefits derived from the problem
- Ensuring the problem is stated in concrete, specific terms
- Adopting the client's use of language
- Taking a one-down position
- Establishing a non-blaming, problem solving atmosphere

### Step 2. Identifying the Attempted Solutions

The purpose of this step is to identify the ways in which the parents have tried to solve the problem before coming to counselling. It is likely that these attempted solutions will show how the problem has been maintained and what the counsellor should not attempt to do. The counsellor needs to come to an understanding of what the main theme or central thrust of the attempted solutions is. For example, if the solution has been to give the child more foods that he/she likes or more interaction time with the parents or more time watching t.v., then the main thrust of their approach is that they seek to solve the problem with kindness or seek to appease the child. If, on the other hand, they take away t.v. time, engage in verbal

tirades, take away allowances and other privileges, then the main theme is a demand for obedience and the thinking involved is linear.

It is often these "solutions" which maintain the problem and that must be altered if progress is to be made. Therefore it is important for the counselor to make sure to ask some questions which will tell him/her what has already been tried. The following are some questions which can be asked to elicit this information:

1. How have you been attempting to handle or resolve this problem?
2. Everybody tries as best they can to deal with their problems: I would like to know what things you have been trying to solve the problem.
3. Are there other people who have helped you to deal with this problem?

### Step 3. Setting Goals in Concrete Terms

The purpose of this step is for both the counsellor and the clients to be clear about what they want to achieve. Often, clients may have vast, undefinable goals such as "communicating better" or "understanding why we do things". It is the counsellors role to press for more specificity. Besides the obvious goal of getting the child to attend school the counsellor will need to find out other information about goals. Some the following questions may be useful:

1. At a minimum, what would you hope to see happen or be different?
2. What at the very least, would you like to see happen as a result of counselling?
3. What would be a significant indicator of change or proof that something has happened?
4. What would be a sign of a positive step?
6. Who else will be affected if you changed?
7. What else might change?

#### Counsellor Activity

- ask questions to elicit an agreed upon, concrete goal

#### Homework

The homework is to be given after the first session. But since the first three steps may not have been completed at this point the assignment may be given while the family is still exploring and defining the problem or identifying attempted solutions.

The family is to be asked to make careful observations of what takes place (who says what to who, when it is said and so on) and what the results of the interactions are. Any family interactions they feel are significant will be accepted but they should pay special attention to events related to going to school. Both positive and negative events are to be included. The following log form will be used:



Family Log

Date:

Time of day:

Who took part in the event:

Describe what took place:

What were the results?

Step 4. Reframing with Positive Connotation

The purpose of reframing with positive connotation is to re-state the interactional cycles brought by the family in a new and positive way which changes the meaning attributed to the situation. Thus, the counsellor will explore the positive aspects of the child's non-attendance at school.

Examples

#1. In a case where the child and the parents have a high estimate of the child's abilities and the parents have gone to great lengths to support and encourage the child in his pre-school years, the situation can be reframed as an issue of loyalty.

Counsellor: (to parents) It seems quite clear that Junior's more than smart enough to cope with school. But it seems to me that besides the possibility of his fearing failure at school there might be other explanations. One of the possibilities is that his apparent fear of failure is his

way of letting you know how important for him your encouragement has been? Also, it may seem like being disloyal to you if he were to earn the kind of encouragement from the teacher that you've given him. (to child) It feels quite good when mummy and daddy tell you how well your doing doesn't it?

Child: Uh-huh.

Counsellor: Might it be that you make them feel good when they can do this for you?

If the parents and the child accept the notion that the school refusal behavior is happening because of their mutual desires to be good to each other there attention should be refocused onto their interactions as a family system. In this way less pressure may be put on both sides to please the other resulting in a resumption of age appropriate behavior on Junior's part.

#2. In a case where the child appears fearful, anxious and sickly which seems to trigger a protective response from the mother. This protective-dependent situation can be defined as one in which Junior sees mum as being lonely without him and he, like her, is very giving.

Counsellor: (to mum) It seems to me that you are a person who is sensitive to the needs of others and who is quite accommodating in meeting those needs. But I wonder if what your doing with Junior is giving you the result that you want?

Mother: I'm not sure. Probably not.

Counsellor: I'd like you to consider the possibility that Junior's fearfulness and anxiety are related to his wanting be as kind and protective towards you as you have been towards him.

If the child is behaving as he does out of kindness towards his mum, then attention can be shifted away from what is wrong with the child towards the relationship between mother and child. This would, hopefully, allow both mother and child to explore new ways of behaving.

#3. In some cases the child's lack of attendance might be related to something that is happening at the school. For example, there may be tense relations between the child and his teacher which the child feels incapable of dealing with. Whatever the case may be, the counsellor must not blame the teacher but rather should support him/her.

Counsellor: It appears that Junior, by misbehaving, is trying to teach the teacher (obviously not very successfully) how he needs to be treated if he is to maintain his self-respect and be a good student. Obviously he needs to maintain his self-respect but perhaps he could use some help in conveying this to the teacher in a more effective way.

#4. Quite frequently an episode of school refusal occurs when the child has been required to attend a new school. In this case the parents may attribute the refusal

to the fact that the child has no friends in the new school.

Counsellor: One possible explanation for Junior's fear of attending school is that when he gets involved with people he does so very strongly, he becomes very attached and so he does not want to get involved with new friends just now because he hasn't let go of his old ones yet. Instead, he is fulfilling his need to be close to people by staying close to you (referring to the parents).

#5. A position that the family may agree upon is that the child is shy. The counsellor could reframe this as the child needing to feel close to his/her family.

Counsellor: Acting shy allows Sally stay close to you. In this way she can let you know how important you are for her and at the same time feel re-assured that she is important to you.

#6. In a case where the precipitating event seems to be the illness of the mother, the counsellor may say to the mother, "Since Jeannie is so very concerned about your health she may be trying to tell you how much you mean to her and at the same time giving you the help and nurturance that she feels that you need.

#7. In a case where the parents feel manipulated by a willful and dishonest child, a new meaning needs to be attributed to the child's actions:

Counsellor: Since Junior has lied to you about his feeling ill you feel, rightly so, manipulated. But it occurs to me

that he is trying to tell you something. Perhaps, without even knowing it, he feels that he needs to be near his mum and doesn't know another way of saying this without lying.

#### Counsellor Activities

- reframing the symptom in terms acceptable to the positions of various family members.
- giving the symptom a positive connotation.
- assessing the acceptability of the reframe to the family.

#### Homework

A successful reframe should imply some different way of behaving. Family members should be asked to continue to think in the ways suggested by the reframe and to notice any differences that may occur. The counsellor does not need to be specific about what the differences might be since the family will respond in it's own unique way. The parents will be asked to record their observations in a log to be shared in either the telephone consultation or the next session.

#### Step 5. Consolidation and Follow-Up

The four steps outlined above should be accomplished in the first two or three sessions. There will be a consultation by telephone between the third and fourth sessions. The telephone consultation and whatever time may be left in the third session after the first four steps are

accomplished will be used to consolidate the reframe and/or to follow-up on the work that has been done so far (which would include dealing with difficulties arising out of the work that has been done).

Once the reframe has been made, discussions in the subsequent sessions will need to establish the reframe. It is assumed that the old way of doing things had some adaptive value for the family and in some cases, may have had a fairly long time to be established. Restating the reframe in slightly different terms and helping to connect it to other things that the family may bring up will help to consolidate it. Throughout this consolidation phase the counsellor will continue to emphasize the positive aspects of the symptomatic behavior.

#### Example

Not being able to achieve the central position at school that the child enjoys at home was reframed as the child being loyal to his family. This might be consolidated by finding other ways that the child is loyal to his family.

Counsellor: What you've said about Junior preferring your company to that of other kids his age might be another example of his tremendous sense of loyalty to you.

#### Problems with Accepting the Reframe

Sometimes family members may show signs of having difficulties accepting the reframe the counsellor has

presented. The family may merely look uncomfortable or they may begin arguing with the counsellor or offering reasons why the reframe is not acceptable. How the counsellor responds to this resistance will depend upon the degree of the resistance. It is not necessary for the counsellor to back away from a reframe at the first sign of resistance since some discomfort with the reframe should be expected since it, by definition, is somehow divergent from the family's usual way of viewing the problem. For example, in the case cited above where the family feels manipulated by their child and the counsellor has reframed the child's actions as being the only way that the child knows how to convey his need for closeness to his mum the family may respond as follows:

Mum: If he wanted to be close to me all he needed to do was say so and I'd find time for him.

Dad: I think he just wants to get out of going to school.

Counsellor: (to mum) I'm sure you would find time for him.

(to dad) You could be right. You know Junior better than I do. But I still feel it's a possibility and I'd like you to consider it a little during the next week before you decide finally whether or not to accept the idea.

Nevertheless, it is important for the counsellor to be prepared for extreme resistance by having a second reframe ready. The second reframe would not be used except when the family offers new information relevant to the reframe which renders the reframe obviously untenable or when, in

the counsellors judgement, the resistance becomes so extreme that he/she feels that the alliance between the counsellor and clients is definitely about to be destroyed. Even when rejecting a reframe seems indicated it may still be possible to offer a reframe which is similar to the original one. Some effort should be put into helping the family to accept the reframe before considering switching to a new one.

### The Phone Call

By the time the family leaves the third session they should have a clear idea of the reframe and in some cases they may even have had some time to think about it and to make a beginning at fitting it into the way they think about the problem. The parents will have been given a log to record their thoughts about the reframe in and a time will have been set for when the parents are to expect the phone call from the counsellor.

Thus, the log is what the conversation would be focused around. However, the counsellor should be prepared to frame the parents behavior subsequent to the reframe as positive. In the case of the family where the child appeared to be manipulative, the parents may take the position, by the time of the phone call, that Junior wasn't motivated solely by a need to be near his mum. At the same time, they may have partially accepted the reframe and thus decided to have mum spend some time with Junior each day



while still insisting that he go to school. The counsellor ought to compliment them on their understanding of the situation and on the action they have taken. Since the goal, in all cases, of the reframe has been to have family members begin to think about the problem in a way that is somewhat different than they had previously, then if it has prompted them to take some action which was different this is sufficient for the counsellor to complement them of their behavior.

#### The Final Session

The work of consolidation and of framing parental behavior which is subsequent to the reframe as positive will continue in the fourth and final session. Some time might also need to be spent on considering how things are likely to go wrong and what might be done about it. If the clients are saying that the presenting complaint has been resolved then counsellor needs to ask a few questions to determine if this is so and to see in what ways things have changed. Also, the counsellor will want to prepare the client for re-occurrences of the problem and will define these as "normal" even when progress has been good. This may help the clients from panicking the first time a problem comes up. Rather than reassuring the client the counsellor wants to create a situation where they likely to be open to continuing to think about the problem in different ways than in the past.

If the problem is clearly not resolved the counsellor may be able to set things moving in the right direction through continuing the consolidation process. However, in cases where issues aside from the school refusal problem have come up-- issues that would require the setting of new goals-- then the counsellor should make this known to the school counselling personnel so that they can provide the necessary additional counselling or make a referral to another resource.

#### Assessment

During the sixth week after the counselling started attendance records will be checked to see how the child fared over the period of the counselling. After a period of three months the attendance records of the children in the study will be again checked and compared to the attendance records of their classmates. Also, the Child Behavior Checklist and the Structural Analysis of Social Behavior which were filled out before the sessions began will be filled out again three months after completion of the counselling.

## Appendix C

Materials Given to Parents:

Participants' Information, Consent Form,  
Instructions for Home Practice, Home Practice  
Log, Log of Family Interactions.

### PARTICIPANTS' INFORMATION

This project is designed to help parents find better ways of dealing with children who have school attendance problems. We are also interested in how people change their ideas and behaviors as a result of counselling.

The research project is offering you a program of four counselling sessions to help you deal with this problem. The person you will be seeing is a graduate student in counselling who is specially trained to assist you with this issue. Many people have found the kind of help we are offering beneficial.

Your part is to attend the scheduled sessions-- if you qualify and choose to participate-- as a family (parent(s) plus the child who is having the attendance problem). It is also necessary that your child participate willingly. He/she will have the project and its potential benefits explained to them in a language suitable to their age level and their consent will be needed so that they can be included in the project. The sessions will be audio taped to help your counsellor with her/his tasks. At your request the taping can be halted and or discontinued anytime during the session. All the tapes will be erased after the project is completed.

You will be asked from time to time to complete a few questionnaires. There are no 'right' or 'wrong' answers; we would like to have the benefit of your thoughts to better understand the way people solve problems. The forms will be completed privately and will not have your name on them (a code on the form will allow the researcher to keep things in order for later analysis). Your identity will be kept confidential, only your counsellor and the researcher will know your real name. Some information concerning past school history will have been examined by the researcher and school personnel in order to identify potential participants. For those who agree to participate, additional information in the form of a questionnaire will be requested of your child's classroom teacher.

We hope and expect that you will benefit from counselling and believe that persons with similar problems will benefit as a result of the study. Should you decide to withdraw from the project you may do so at any time. If you tell us of your wish to discontinue, we will give you a list of other resources available in the community.

Whether or not you choose to participate in the project will not affect the availability of services from the School or the School District. Participants of the project can obtain a copy of the written report after the project is completed by contacting Dr. Adam Horvath c/o Simon Fraser University, Faculty of Education.

### Informed Consent to Participate

Your signature on this form will signify that you have received the document describing this project, that you have had adequate opportunity to consider the information in the document and that you and your child voluntarily agree to participate in the project.

NAME (Please print) : \_\_\_\_\_

ADDRESS : \_\_\_\_\_

\_\_\_\_\_

Having read the attached information I agree to participate with my child in the project. I understand that my participation is voluntary and that I may withdraw my consent at any time. I also understand that I may register any complaint I might have about the project by contacting Dr. Adam Horvath, or Dr. Stan Shapson (Associate Dean, Faculty of Education), Simon Fraser University.

Signed:

PARENT or GUARDIAN : \_\_\_\_\_

CHILD : \_\_\_\_\_

WITNESS : \_\_\_\_\_

Once signed, a copy of this consent form and a subject feedback form will be provided to you.

## Instructions for Home Practice

### Rationale for Desensitization

Your help in practicing the relaxation exercise is much needed. It is important that you learn how to do the relaxation exercise so that you can do it with your child. Your child's difficulties may be a result of becoming tense near (in) school. She (he) is trying to avoid this tense feeling that is associated with school. This is a method that will assist you and your child to control your tenseness in progressively more difficult situations. The best way to avoid being tense is by being relaxed. If you can make yourself relaxed at will then you can "turn your relaxation on" in situations that make you tense.

### Relaxation Exercise

- Before beginning the exercise the child and parent(s) will need to be in a comfortable position with loose clothing and body supported.
- Take a deep breath, breathing in slowly through your nose using your tummy to pull in the air. Hold it for the count of 5-- 2, 3, 4, 5. Let it out slowly. The air brings in relaxation and breathes out tensions.
- Close your fist squeezing as tightly as possible feeling the tension in the muscles of your hand. Hold it for a count of 5-- 2, 3, 4, 5. Now release your hand and feel the tension going out of your hand. You will feel this sense of release of tension as we tense and release muscles in other area of your body.
- Repeat fist squeezing with the other hand.
- Tense and release muscles in one foot and then the other.
- Tense and release calf muscles.
- Tense and release thigh muscles.
- Continue tensing and releasing with buttocks, abdomen, stomach, chest, upper arms, neck and face.
- Take a deep breath sending relaxation to any tense parts of your breathing out tensions.
- Relax and enjoy the heaviness of your muscles and your sense of relaxation.
- Now I would like you to picture a long, black wall stretching into the distance. Imagine yourself walking slowly along this wall. On this wall are large, white numbers from 1 to 10. Your walking past number 1 now and continuing to feel relaxed. As you move towards number 2 you feel slightly more relaxed. You now slowly moving past 2 towards number 3 and as you do, feel a little more relaxed still. (This is continued until reaching number 10 which is described as being very, very relaxed).

### Imaginal Hierarchy Presentation Method

Your child is asked to visualize an item in as much detail as possible. If anxiety occurs with any scene, the child is asked to hold the image, to continue the visualization, and to continue to relax away the tensions.

In this way the client will face a situation like a real life one since he/she will not be able to "eliminate" the situation in real life either-- it is a coping model. If extending the relaxation exercise does not succeed in relaxing the child, the child is asked to stop generating the anxiety producing image and to return to the beginning of the exercise which will not be re-introduced until relaxation has been achieved. The child will have to be told to give a signal, such as raising his/her index finger, to indicate that anxiety is being experienced while an hierarchy item is being presented so that the parent will know that he/she needs to continue with the relaxation until it is successful.

## Home Practice Log

- 1) Please fill out the log each day whether you were able to work with your child or not.
- 2) Make your work with your child a non-stressful time for you and your child. Pick a time when you both feel good and when interruptions are unlikely.
- 3) Please check-off the level of the hierarchy that you got to each day that you practiced.

Date: \_\_\_\_\_

Time started: \_\_\_\_\_

Time finished: \_\_\_\_\_

Activity: \_\_\_\_\_

Hierarchy Level

1) \_\_\_\_\_

2) \_\_\_\_\_

3) \_\_\_\_\_

4) \_\_\_\_\_

5) \_\_\_\_\_

6) \_\_\_\_\_

7) \_\_\_\_\_

8) \_\_\_\_\_

9) \_\_\_\_\_

Comments about the activity:

Difficulties (if any).

Log of Family Interactions

## Instructions for Homework Activity:

It is important for you (the parent) to make careful observations of what takes place when family members are together (who says what to whom, when it is said, what lead up to it and what the results were). Any family interactions that you feel are significant or typical of how members of your family relate to each other should be recorded. You should pay special attention to events related to going to school (getting ready for school, your child asking to stay home, and so on). Both positive and negative events are considered to be useful to record.

Try to set aside a time that you think would provide useful information and note what takes place.

Date: \_\_\_\_\_

Time of day: \_\_\_\_\_

Who took part in the event (family interaction)?:

Describe what took place:

What lead up to the event?:

What was the result (what happened after)?:



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