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PII: S1077-7229(14)00102-3
DOI: doi: 10.1016/j.cbpra.2014.08.002
Reference: CBPRA 555

To appear in: Cognitive and Behavioral Practice

Received date: 18 April 2014
Accepted date: 21 August 2014

Please cite this article as: Chu, B.C., Rizvi, S.L., Zendegui, E.A. & Bonavitacola, L., Dialectical Behavior Therapy for School Refusal: Treatment Development and Incorporation of Web-based Coaching, Cognitive and Behavioral Practice (2014), doi: 10.1016/j.cbpra.2014.08.002

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Submitted: 4/18/14

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Acknowledgements: We wish to thank the assessment staff of the Youth Anxiety and Depression Clinic at Rutgers, Lauren Hoffman, and Marget Thomas Fishman for their help with this project. This study was supported by a Faculty Research Grant from Rutgers University awarded to the first two authors.
Abstract

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

School refusal (SR) behavior is a multi-faceted and heterogeneous problem set that affects children and adolescents (hereafter referred to as youth) across the age spectrum and is associated with serious health, educational, and legal/status outcomes (Kearney, 2008). SR behavior refers to any youth-initiated inexcusable absence and includes both truancy (illegal surreptitious absences linked to delinquency or academic problems that tend to occur without parental knowledge) and anxiety-based SR (resistance or poor attendance due to anxiety/distress that typically occurs with the knowledge of the parents; Egger, Costello, & Angold, 2003; Kearney, 2008). SR behavior can contribute to partial or whole day school absences, tardiness, missed class time (e.g., nurse or counselor visits), or other disruptions to the youth’s routine that affects attendance (e.g., morning tantrums, sleep difficulties, somatic complaints; King, Tonge, Heyne, & Ollendick, 2000). Youth with chronic attendance problems and SR behavior are susceptible to a number of psychosocial and academic problems that predict poor long-term functioning (Kearny, 2008). Current psychological treatments have been only partially successful, and so developing more robust treatment applications to address this multi-faceted problem are warranted (Kearney, 2008; King & Bernstein, 2001; King et al., 2000).

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

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

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

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

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

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

Standard DBT-A is a 16-week, multimodal treatment that includes individual therapy with the youth, multi-family group skills training with the youth and his/her parent(s), telephone consultation to provide skills coaching outside the therapy hour, and a therapist team meeting. For DBT-SR, 60-90 minute individual sessions and two-hour multi-family group sessions were held once weekly. Web-based consultation was provided on a criterion-based schedule (see below). The group of individual therapists and skills trainers also met weekly for a combination of DBT consultation team and treatment development discussions. In standard DBT, the function of the consultation team is to enhance therapist skills and motivation, provide support, and reduce burnout (Linehan, 1993a). Since this was the first time DBT had been applied to this population and because we were incorporating a novel treatment element (web coaching), the weekly team meeting was used to fulfill that original function and also to discuss “what next” steps as we worked to refine the treatment manual.

**Multi-family Skills Groups**

DBT-A skills training includes five content areas (the first four are found in the original DBT protocol; Linehan, 1993b): mindfulness skills to increase awareness of the present moment,
emotion regulation to learn to understand and change maladaptive emotional experiences, distress tolerance to learn how to get through difficult moments without engaging in impulsive behaviors, interpersonal effectiveness skills to teach how to interact with others more effectively, and “walking the middle path” which aims to teach dialectical, middle path approaches to oneself, others, and one’s problems. The middle path skills translate common conflicts in family life (e.g., negotiating teen independence versus need for family structure and rules) into dialectic concepts (Miller et al., 2007). It helps families navigate typical developmental challenges, such as parent-youth conflict, experimentation with alcohol/drugs, and increased dependence on peers, by understanding the truth in both parent and youth perspectives and negotiating a middle ground. This skill set may be particularly applicable for DBT-SR as research has identified increased levels of general enmeshment, conflict, detachment of individuals within the family, disrupted communication and affective expression, and isolation of the family from other social contacts in families where a youth is school refusing (Kearney & Silverman, 1995).

Multi-family skills groups teach skills to both the youth and the parents to practice themselves. That is, rather than take an “identified patient” approach in which everyone learns skills to help the adolescent apply to him- or her-self, the group targets all family members with the belief that everyone can benefit from learning the skills and applying them to their own lives and interactions. For DBT-SR, we followed the DBT-A manual for the skills training groups and made only minor modifications to materials (i.e., removing references to self-harm or suicidal thoughts, adding references to avoiding school) in order to make it more appropriate for youth with SR behaviors. When youth refused to attend groups, parents were still encouraged to attend. Table 1 provides examples of DBT-A skills and treatment strategies translated to DBT-SR.

**Individual Youth and Family Sessions**
Individual family therapy session procedures are described in a treatment manual and consist of a one-hour youth meeting and 30-minute parent meeting (presence of the youth was permitted when appropriate). Four initial psychoeducational sessions are structured, and then the remaining sessions are guided by a principles-based, modular therapist guide. Session 1 provides psychoeducation about SR and DBT, introduces the Daily Diary Card self-monitoring tool (which is reviewed at the start of each session), and reviews treatment agreements, and treatment engagement. The session serves to build rapport, normalize the intense emotional distress and sensitivity to negative affect that triggers poor attendance, and serves to gather more information about the youth’s individual triggers and behavioral chains. The therapist reviews expectations for commitment to therapy and problem-solves barriers to attendance, a particular concern for this population. The parent meeting reviews the primacy of emotional dysregulation and intolerance of negative affect in the conceptualization of SR and assigns parents to complete a youth-parent interaction tracker to see how family members may maintain SR behaviors.

In session 2, the therapist continues to provide psychoeducation that connects anxiety, depression, and SR, describing how emotional spirals can lead to a quick cascading of behavioral avoidance and distress. An avoidance or challenge hierarchy is then developed that identifies the situations that present challenges to the youth: places where he or she gets stuck, depressed, inactive, or freezes, avoids, and escapes. In the parent meeting, the therapist reviews the youth-parent tracker and identifies individual family patterns. The therapist highlights three common family patterns that impact families with an SR youth: the Accommodation Spiral (parents respond to youth distress by accommodating or facilitated avoidance), the Passivity-Discouragement Spiral (parents respond to youth fatigue, avolition, or hopelessness with passivity and accommodation that reinforces youth’s lack of efficacy), and the Aggressive-
Coercive Spiral (parents respond to oppositional behavior with anger and criticism, leading to escalated aggression). Parents are then taught a dialectical parenting technique we call “Validate and Cheerlead.” In this technique, parents are taught to acknowledge both the distress the youth experiences at the same time that they encourage the youth to choose approach-oriented behaviors in the presence of distress.

Session 3 formally introduces contingency management (reward scheduling) systems to help families develop effective incentives and consequences to encourage desired behaviors and efforts to cope. A strong emphasis of this module is to remove reinforcers that are inadvertently reinforcing refusing behaviors (e.g., removing desirable alternatives to going to school, such as, unlimited television time at home). An equally strong emphasis of this module is to brainstorm incentives that are truly reinforcing to the youth, do not necessarily rely on monetary expenditure, and are renewable daily. As an example, access to the cell phone is a useful incentive to the extent that parents can give access to the phone once a goal has been accomplished (rising from bed, completing morning routine, attendance for part of or whole school days). At the same time, failure to earn the reward on one day leaves available the opportunity to earn the reward the next day. As such, the youth has a daily renewable reward without the risk of working “out of debt,” a situation that occurs when parents increasingly strip youth of privileges when the desired action is not achieved. Both rewards and expectations are negotiated with the parents and youth to enhance engagement and commitment to the system.

In session 4, the therapist reviews family use of reward scheduling and problem-solves challenges to implementation. By this point, the therapist will also have attempted to schedule a school consultation meeting. Session 4 is used to plan this meeting if events have not required an earlier appointment (e.g., school is requiring prompt action by parents). At a minimum, the
therapist, the parent(s), and one school official should be present. This school official (e.g.,
school counselor, school social worker/psychologist, academic teacher, or administrator) serves
as the point-person for the case. Ideally, a school representative who knows the youth best (e.g.,
an academic teacher or counselor) is also included. The goals for the school meeting are to (a)
establish a working relationship/collaboration with the school, (b) exchange information about
the youth’s in-school and out-of-school patterns and efforts, (c) agree on goals for school re-
integration, (d) identify school resources (staff availability, study periods, counselor visits) and
limits (maximum absences before severe consequences set in and nature of consequences), (e)
incentives to use both in- and out-of-school, (f) to brainstorm ways to practice skills inside and
outside of school, and (g) identify ways to track progress and provide feedback.

Realistic expectations for school re-entry should be individualized and negotiated with
parents and schools. Treatment seekers at our clinic tend to be chronic refusers who have missed
over 20 school days or a substantial portion of days for several months or longer. Creating
expectations for 100% attendance after two weeks may be unrealistic, especially when refusal
behavior has recurred over several years. We tend to target 75%-80% attendance within 6-8
weeks. More acute, recent episodes of SR can be addressed more quickly. Such expectations
need to be negotiated within the realities of school rules, but we have found that most schools
welcome realistic goals, particularly when the only other option is to transfer the student to
alternative schooling at great expense to the district.

After the first four sessions, the manual takes a principles-based approach, wherein
problem behaviors are functionally assessed and each DBT-A skill (mindfulness, emotion
regulation, distress tolerance interpersonal effectiveness, walking the middle path) can be used
flexibly to address the most current concerns. The manual provides examples to help place each
skill in the context of SR. The DBT target hierarchy guides therapists in structuring each session, such that life-threatening behaviors take precedence over therapy-interfering and quality-of-life interfering behaviors (Linehan, 1993a).

**Web-based Coaching (WBC)**

In standard DBT and DBT-A, the individual therapist is available to the client outside of therapy sessions via phone (or other methods, like texting or email) to provide coaching in DBT skills in “real world” situations. For DBT-SR, we extended this mode of treatment in two important ways: the medium (web-based) and the timing (early morning when SR behaviors are most prominent). WBC was intended to enhance traditional phone coaching because the therapist could directly observe youth and parent behavior in the natural setting, observe interactions amongst multiple family members, and visually assess environmental variables that may contribute to SR behavior. WBC also allows therapists the flexibility to intervene with one or several members or to provide more passive coaching as a family completes their morning routine. Particularly because youth with SR can be a challenging population to treat, using WBC from a family’s home makes possible a more intensive outpatient treatment model that minimizes the additional burden on families. In contrast to standard DBT in which clients are asked to call the therapist at times when they need coaching in DBT skills, in DBT-SR, web-based coaching was specifically designed to occur in the early morning, before school.

Coaching was conducted using a videoconferencing program called Cisco Jabber, which produces encrypted calls and is adherent to HIPAA regulations. This program delivers higher quality video than Skype and has fewer delays and a higher level of security. Prior to the first WBC session, study staff emailed instructions to download and install Cisco Jabber. Staff then went to participant homes to orient families to the technology and help install equipment.
Families received a high definition webcam, a room microphone, a USB hub, a networking cable, and a technology guide that included step-by-step directions and troubleshooting tips.

WBC sessions lasted five to 30 minutes and had a flexible format that could include the youth alone or both the youth and parents. The frequency of WBC sessions was dependent on number of school days the youth had attended the previous week: daily for attending zero to two days, twice weekly for attending three days, and once weekly for attending four days. No WBC was scheduled if the youth attended all days the prior week. Regardless of school attendance, two brief WBC sessions took place between the first and second individual in-person sessions. The first session was used to test equipment, and the second session was used to observe the family during their morning routine. Therapists helped families choose where to place the webcam to maximize observation of relevant interactions while protecting privacy. Therapists received a high definition webcam and a networking cable for the study. The networking cable was used to connect directly to therapists’ wireless router to improve the quality of videoconferencing.

Target Population for DBT-SR

School refusal reflects a heterogeneous clinical population, reflecting anxiety-based SR behaviors (characterized by anxiety and depression), truancy (characterized by conduct disorders, defiance, and substance abuse), and mixed forms of anxiety and oppositional behaviors (Egger et al., 2003; Kearney, 2008). DBT-SR was designed for non-truant refusal behaviors, focusing on the intense emotional and behavioral dyscontrol that come with anxiety and mood disorders. Youth with comorbid conduct and defiance problems could be included as these youth (and parents) would likely benefit from DBT-SR skills. However, intensive conduct problems, marked by severe aggression, legal troubles, or substance abuse would best be
addressed more directly with multi-systemic approaches or conduct-specific interventions, such as Anger Control Therapy or Problem-Solving Skills Training (Eyberg, Nelson, & Boggs, 2008).

**Open Pilot Trial of DBT-SR**

**Setting, Participants, and Procedures**

All assessment and therapy procedures took place in a university-based research clinic. Recruitment was conducted through advertisement to local schools and by inviting appropriate clients through an in-house youth clinic. Inclusion criteria were (a) youth between the ages of 12-16 years-old, (b) SR for anxiety/negative-affect related reasons, (c) the family owned a computer, and (d) the family agreed to keep any medication dosage stable during the course of the study. Youth were excluded if (a) conduct disorder or oppositional defiant disorder was a principal diagnosis, (b) parent reported any diagnosis of intellectual disability, psychosis, bipolar disorder, or autism, (c) youth was receiving other psychological services and the family was unwilling to forgo this treatment during the study time period, and (d) there was an indication of moderate or higher youth suicidal ideation with a plan to attempt.

Seven families participated in pretreatment assessments, all were eligible and invited to participate, and four families enrolled in the open trial. Participants were a 16-year-old boy (Youth 1) with SR, Major Depressive Disorder (MDD), and Generalized Anxiety Disorder (GAD), a 14-year-old boy (Youth 2) with SR, GAD, and Social Phobia (SOP); a 15-year-old girl with SR and MDD; and a 13-year-old boy with SR, SOP, specific phobia of shots, GAD, and MDD. Further details are provided in the case reports below. Family group leaders were two licensed psychologists with expertise in youth internalizing disorders and DBT (the two first authors). Individual therapists were four female, Masters-level psychology doctoral students, receiving weekly supervision by the two licensed psychologists. All participants completed
consent/assent procedures and all procedures were approved by the university’s Institutional Review Board.

Assessments

A full assessment battery was administered at pretreatment, midtreatment (after group 8), posttreatment, and at 4-month follow up. However, for the purposes of this paper, only pre, post, and follow-up measures reported in the case studies below are described. To assess diagnoses, the Anxiety Disorders Interview Schedule– Child and Parent version (ADIS-IV-C/P; Silverman & Albano, 1996) was used. The ADIS-IV includes Clinical Severity Rating (CSR) scores which youth, parents, and clinicians use to measure level of distress and/or impairment of functioning relative to each disorder endorsed, ranging from 0 (none) to 8 (very much). A score of 4 equates to a clinical diagnosis. Evaluators also completed the Children’s Depression Rating Scale-Revised (CDRS-R; Poznanski & Mokros, 1996), a clinician administered measure used to assess depression severity over the past week. To assess for severity of symptoms over time, the Clinical Global Impression – Severity (CGI-S) was used (National Institute of Mental Health, 1985) and rated on a 1 (not at all ill) to 7 (extremely ill) scale.

Youth and parent self-reports of treatment satisfaction were rated on a 1-5 scale, with lower numbers indicating less satisfaction and a score of “3” equating a neutral description for most items. Similarly, ratings of satisfaction were gathered for each of the treatment components including individual therapy, web-based coaching, and multi-family skills group following the same five-point Likert-type scale.

General Feasibility and Acceptability

Attendance rates differed across youth and across individual, web-based coaching, and group formats. Youth 3 (15-year-old girl) attended one individual and one group session before
dropping out of the study. Her reason for attrition was that the group was “too structured” and spent insufficient time on youth interactions. She objected to parents being included in the groups (this youth had had prior experience in a youth DBT group without parents). Youth 4 (13-year-old boy) dropped out of treatment after attending one individual session. He had recently started another mindfulness based treatment program that he wanted to continue in lieu of DBT-SR. (For the remainder of this paper, only Youths 1 and 2 will be included.)

For individual sessions, Youth 1 attended 17 of 20 scheduled sessions, and Youth 2 attended 15 of 25 scheduled sessions (including re-scheduled sessions after missed meetings). Youth 1’s missed sessions resulted from youth’s refusal to attend, and Youth 2’s missed sessions resulted from youth’s refusal and parents’ last-minute cancellations for multiple reasons (e.g., other family emergencies, work-related scheduling). For WBC, Youth 1 appeared for 36 out of 46 scheduled sessions, and Youth 2 appeared for 41 of 48 scheduled sessions. Youth 1 missed WBC sessions due to refusal to come to the computer when the therapist called, resulting in frequent parent and/or youth phone coaching. The majority (71.4%) of Youth 2’s missed WBC sessions were due to same-morning cancellations by his parents and some were due to “no shows” (14.3%). Out of a possible 16 group sessions, Youth 1 attended 8 sessions, his mother attended all 16, and his father attended 15. Youth 2 attended 11 of 16 group sessions and his mother and father attended 12.

At posttreatment, mean ratings of youth satisfaction demonstrated low to moderate satisfaction for all treatment components: global satisfaction ($M = 3.5$, range = 2 – 5), individual therapy ($M = 3.5$, range = 2 – 5), web-based coaching ($M = 3.6$, range = 2.2 - 4.9), skills group ($M = 2.3$, range = 1.8 - 2.7). Parent mean satisfaction was higher than youth counterparts across
all components: global satisfaction ($M = 4.8$, range $= 4.3 - 5$), individual therapy ($M = 4$, range $= 4 - 5$), web-based coaching ($M = 4.8$, range $= 4.6 - 4.9$), skills group ($M = 4.3$, range $= 3.7 - 5$).

**Feasibility and Acceptability of WBC**

The two families who completed treatment attended 36 and 41 WBC sessions. Families averaged 1.97 ($SD = 1.7$) sessions per week (range: $0 - 5$). WBC sessions averaged 16.6 minutes ($SD = 8.9$) and ranged from 4.0 to 43.0 minutes in length. All WBC sessions began between 6:30 a.m. and 9:30 a.m., with 83.8% of WBC sessions beginning between 6:30 a.m. and 6:59 a.m.

When asked how WBC sessions helped, participants commonly noted that WBC provided the youth “real-time” support and encouragement when the youth needed it most (“[The most helpful part of WBC was] having someone to talk to when I felt my worst”), improved routine or sleep regulation by providing structure in the mornings (“My son would get up in the morning specifically for WBC where he may not have gotten up otherwise”), helped parents feel confident that therapists were seeing real examples of the dysfunction (“It gave [the therapist] un-edited, real-time view of the challenges we have been living with”), and helped parents/youth practice DBT skills with active coaching (“[WBC helped my son] practice the skills learned in group at a difficult time (early in the morning) when he felt tired and unable to get up.”).

Of 77 WBC sessions, therapists noted a total of 49 technical problems in 37 sessions (49.3%). Audio or video lags were the most common and took place in 17.3% of sessions. Other technical problems included the program cutting out or freezing, broken up audio or video, and Internet problems. Despite the frequency of technology problems, participants reported that WBC video and audio quality was high. Clients reported that WBC video and audio quality were high, with means of 4.06 ($SD = 1.23$) and 4.10 ($SD = 1.22$) on a scale of 0 (“Coaching could not be done”) to 5 (“Flawless- like in person”), respectively.
Illustrative Case Examples

Youth 1

Ricky was a 16-year-old, Caucasian boy in the 11th grade at a public high school who lived with both parents. At intake, Ricky was diagnosed with MDD (CSR = 5) and GAD (CSR = 4), with overall functioning in the “markedly ill” range (CGI-S = 5). SR behavior was endorsed with severe impairment (CSR = 6). Interviewers also gave Ricky a 53 on the CDRS-R, indicating symptoms in the 98th percentile of same-aged peers for depression. Ricky was taking an anti-depressant medication. See Table 2 for pre- and posttreatment diagnostic profile.

At intake (mid-December), Ricky had missed 26 school days (41% of possible days) of the current school year and 13 days (50% of possible) in the past month. His long history of SR was related to gastro-intestinal distress secondary to contracting a bacterial infection in the 7th grade. Periodic medical absences led to Ricky falling further behind, contributing to anxiety about homework and tests. Ricky demonstrated increasing depression and isolation from family and friends as attendance problems persisted, leading to significant academic problems. Significant family conflict resulted from alternating attempts by the family to exert “tough love” and accommodation (Ricky’s SR was one reason his mother did not seek employment).

Ricky and his mother first appeared highly motivated for treatment. The “devil’s advocate” strategy was used to elicit a strong commitment to treatment by posing questions like, “This program is asking a lot from you and it’s going to be hard to follow through with all of it. Why would it make sense to commit to all of this?” Ricky answered stating, “Because I have nothing to lose. I can do anything for 16 weeks and if I feel the same, I haven’t lost anything.” Ricky completed daily diary cards and parents completed youth-parent interaction trackers.

Ricky completed diary cards consistently but had difficulty remembering to bring them sessions.
One consistent pattern reflected the relation between refusal behaviors and high intensity emotions (usually distress or sadness). Positive emotions were associated with socializing after school or on weekends.

Contingency management was introduced, and a re-entry plan was drafted that included the hierarchical goals of: getting out of bed by 6:45 a.m., not returning to bed once out of bed, limiting bathroom time to 30 minutes, driving to school, staying in school for one class period, and concluding with staying in school for the whole day. These steps were brainstormed and developed early in treatment and flexibly applied as new behavioral patterns emerged. For instance, multiple chain analyses (see Rizvi & Ritschel, 2014) revealed that Ricky stayed in school once he was there, but getting out of bed and into the car was most challenging. Graded steps focused on approaching school (e.g., going to school but staying in the counselor’s office; going to school for just one class) with many morning routine sub-steps (e.g., engaging in something active when he gets out of bed; taking a short bath to self soothe stomach pains). A reward plan was developed for Ricky, so that each target behavior was reinforced with desirables (time spent on the computer and other electronics, time with friends, and driving the family car).

Once this plan was in place (session 4), the majority of Ricky’s individual sessions focused on identifying behavioral patterns that maintained SR behavior and ways to maintain treatment engagement and practice effective behaviors. Chain analyses identified Ricky’s personal vulnerabilities included failure to take medication on time/as prescribed which affected his routine, irregular sleep patterns, and eating foods that upset his stomach. Ricky’s intestinal disorder meant that he would experience extreme constipation and discomfort. Consultation with his gastrointestinal specialist confirmed that discomfort was expected after eating certain foods,
but she also confirmed that past treatments cleared Ricky of any ongoing infection and that no further damage would occur during physical activity.

The *PLEASE skills*, taught in the multi-family group sessions, were reinforced in individual sessions to reduce personal vulnerability, appropriately manage physical illness, and achieve balanced eating, sleeping, and exercise. For Ricky, this meant taking his medications consistently and stabilizing his sleep cycle (in bed by 11 p.m. and up by 6:45 a.m. on weekdays). These tasks were added to his contingency plan so that he could earn rewards for achievement.

*Opposite action*, an emotion regulation skill that encourages actions opposite to those dictated by an emotional urge, was used to help Ricky find alternatives to isolating and de-activating when feeling pain and sadness. Instead, he was encouraged to throw himself into being active and social with others. To help enact opposite action, Ricky practiced multiple distress tolerance techniques to help him accept his pain without making the situation worse (e.g., by refusing to get out of bed). Distracting activities (e.g., going for a walk, playing “Dance Dance Revolution,” doing chores, and playing with his dog) were some of the most successful. Ricky was also encouraged to use the distract skill of “pushing away,” in which an individual pushes the painful situation (e.g., gastro-intestinal pain) out of one’s mind temporarily to make it through the distressing moment. *Radical acceptance*, a strategy aimed at accepting the current moment with your mind and body, was emphasized throughout. In session and during WBC, the therapist helped Ricky practice being mindful of his physical pain, acknowledge and self-validate his feelings, and accept the moment as it was. These interventions helped give Ricky control over the moment even though he often struggled with embracing the concept of acceptance.

Challenges included treatment engagement and parent discouragement. During individual sessions and in group, Ricky was almost always agreeable, talkative, and cooperative. Outside of
therapy, Ricky rarely followed through with homework and occasionally refused web or phone coaching. He also attended a minority of group sessions. On these occasions, the therapist used phone coaching and implemented DBT techniques such as irreverence, radical genuineness, and the “freedom to choose, absence of alternatives” and “foot in the door” commitment strategies. The therapist moved Ricky towards making a personal choice to engage in DBT-SR as the most appealing of the options.

A second challenge was inconsistent father participation and mother self-efficacy. Ricky’s father often worked night hours and so would be less available in early morning hours. When the father would engage in morning routines, he would often be critical and abrupt. In contrast, the mother was consistently supportive and engaged during sessions and willing to try new skills (e.g., validate and cheerlead). However, at home, she would often report feeling helpless to Ricky’s moods and opposition, expressing statements like, “He’s like a politician, finding any little loophole to a rule,” or “I don’t know what else to do. I’ve tried so many things in the past that haven’t work; I’ve felt like giving up.” When the mother would become more directive at home, Ricky would become verbally aggressive. The therapist emphasized the “middle path” skills of validation and cheerleading by having her say, “Ricky, I know you’re feeling very sick right now and that sucks. I also know that you can get out of bed and make it to school even though it’s hard right now.” Using these techniques along with consistently acknowledging Ricky’s progress appeared most helpful in moving Ricky toward school. Validate and cheerlead was also helpful for the father to learn, as was becoming more adept at delivering positive reinforcement. Video 1 demonstrates a WBC session teaching parents these skills.

WBC sessions were scheduled throughout the course of treatment with Ricky and/or his mother. They received 36 sessions that focused on three priorities: to assess SR behavior, to
conduct in vivo skills coaching, and to conduct in vivo skills coaching with Ricky’s mother to implement the contingency plan or practice skills. The sessions were scheduled more frequently in the beginning of treatment (daily) and titrated down towards the end. Phone coaching was made available to both Ricky and his mother as a way for them to reach out to the therapist when SR occurred outside of scheduled WBC sessions. The WBC software and hardware appeared very acceptable and easy to implement for both the family and the therapist with minimal difficulties experienced throughout the course of treatment. WBC sessions also appeared to give critical support to the mother who was interested in, but insecure with, delivering DBT skills at home.

By the end of treatment, Ricky stated that he appreciated learning his behavioral patterns. Although Ricky’s insight improved, his willingness to attend school when in pain only slightly improved. Ricky’s commitment to implementing the DBT skills and attending treatment waxed and waned during treatment. Ricky made progress in increasing mindfulness of his emotions and increased his school attendance (though tardiness continued to be an issue), but the degree to which he actually practiced his skills is unclear. At posttreatment Ricky only met criteria for School Refusal (CSR = 6) and at follow-up, he no longer met criteria for any diagnoses according to clinician-administered parent and youth interviews.

Youth 2

Lance was a 14-year-old, Caucasian boy, enrolled in the 9th grade at a private school. His parents were separated and had joint custody. At intake, Lance was diagnosed with SR (CSR = 7), GAD (CSR = 6), and SOP (CSR = 4), with overall functioning in the “markedly ill” range (CGI-S = 5). See Table 2 for pre and posttreatment diagnostic profile. Lance took no psychotropic medication. His SR began in 8th grade, following an illness, and he finished the
school year with home tutoring. In 9th grade he had difficulty returning after a weather-related school closure and again after an illness. At intake (mid-January), he had not attended school for six weeks though winter break made up several of those weeks.

Lance’s refusal behaviors related to fears of explaining his absence to others at school or elsewhere, performance fears, social evaluation, and catching up on schoolwork/homework. He reported no short-term impairment but was concerned that continued absences may negatively affect long-term goals, like going to college and getting a job. Lance noted numerous benefits to staying home, including sleeping in, watching TV, playing video games, being free of worry about school, and spending more time with good friends because he did not have to commute to school or do homework. His parents reported that SR interfered with grades, social relationships, and family functioning.

Numerous DBT skills were essential to the family’s progress. Walking the Middle Path skills were a central skill. Broadly, therapy focused on helping parents move towards synthesis of the “Holding on too tight—Forcing independence too soon” dialectical dilemma (Miller et al., 2007). The parents often yielded authority to Lance on school reentry (if, when, and how), yet they avoided talking about school with Lance or in front of him, because they considered it “too upsetting for him” (e.g., they gave Lance permission to miss therapy and stop WBC because talking about school and going to therapy was too stressful). Here, parents expected adult-like decisions on one hand but acted in very protective ways on the other. Therapy focused on helping parents take more control over decisions reserved for parents (e.g., school attendance, choice of schools) while remaining emotionally supportive. As an example of the “Too loose – Too strict” dialectic, Lance would often refuse to go to bed but then blame his parents for being tired in the morning and fail to get up. Here, the therapist highlighted the need to consistently
implement the contingency management plan (using laptop time as a reward and maintaining structure over its use), as opposed to allowing un-restricted use and then arbitrarily removing it when angry.

Validation was also critical, as the family had a history of conflict, criticism, and blame that often led to escalating emotional arguments. The therapist used session time to have family members practice using validation with each family member. Practicing validation appeared to deescalate conflictual conversations, decrease judgment by increasing perspective taking, and increase acceptance. This process highlighted the importance of the acceptance-change dialectic, even as family members had varying levels of success in demonstrating validation either with the coach or independently.

There were numerous challenges to treatment. Most notably, the family missed, was late to, or cancelled at the last minute numerous individual, group, and WBC sessions. This was most often due to Lance’s refusal to come to therapy but also due to parental tardiness or family/personal crises not related to SR. Further, Lance often became unresponsive when the therapist tried to address school topics directly discussed. The family’s inconsistency and Lance’s avoidance of emotional topics led to a large proportion of session time dedicated to treatment engagement exercises and motivational interviewing. The parents’ own avoidance of the topic (as discussed above) only reinforced the youth’s avoidance and gave little incentive to participate actively in session. In the sixth week of the program, Lance began psychopharmacological treatment with an SSRI, and he reentered school in the 12th week. After school reentry, the family’s treatment attendance decreased and commitment became unstable. Decreased attendance may have resulted from continued treatment disengagement, recovery
from distress via DBT-SR or the medication, or logistical challenges with balancing travel to school, homework, and travel to the treatment facility.

It should be noted that Lance’s mother and father both acknowledged gaining personal benefit from participating in the skills group. Lance and his mother’s emotion dysregulation were intertwined in a number of ways. For example, the mother had difficulty tolerating Lance’s distress and would become upset when Lance was distressed. When upset, the mother resorted to coercive tactics to elicit Lance’s compliance with desired behaviors (e.g., screaming and threatening when it was time to go to therapy). Practicing skills with the mother helped her keep her emotions regulated and adhere to family interventions calmly (e.g., contingency management; avoid switching between “Too loose” and “Too strict”). The father presented with greater emotion regulation, but he self-acknowledged having an avoidant coping style. This often meant the father avoided communicating with the therapist or telling the therapist at the last-minute when he had done something against recommendations (e.g., cancelling WBC at midnight by text because he had made a deal with Lance that he did not have to get up for coaching). As a result, the father would agree with therapist recommendations in session, but then fail to consistently implement strategies at home.

Lance’s treatment relied heavily on WBC and phone coaching. WBC was scheduled nearly daily until Lance reentered school. Having coaching take place via videoconferencing was particularly helpful because the therapist could see and speak to multiple family members in order to assess interactions between family members. Videoconferencing was also helpful because the therapist could see Lance’s body language when he was not verbally responsive. In WBC sessions, the therapist initially focused on using validation and cheerleading to help Lance get out of bed. In later WBC, the therapist targeted implementing the contingency management
Dialectical Behavior Therapy for School Refusal

plan, completing morning exposures, and helping Lance use DBT skills to complete the morning routine and exposures. For example, coaching often focused on helping the parents use the Walking the Middle Path skills to help Lance get out of bed and to execute the rewards plan faithfully. Mindfulness was also used, particularly with the mother, who was coached to use the “Describe” skill and to avoid judgments when discussing other family members’ behavior. The mother was also coached to use Wise Mind, particularly by staying focused on the present moment, when implementing the reward plan. During WBC in which Lance was particularly tired or distressed, Lance was coached in using self-soothe with music and in opposite action. Video 2 demonstrates a range of skills used during WBC sessions with Lance’s family.

Parents reported that having WBC scheduled in the morning helped to keep Lance accountable for getting out of bed and starting his morning routine. Waking at a consistent time to participate in WBC may have helped Lance regulate his sleep. In addition, it appeared that daily WBC increased his parents’ coordination of childcare, and it helped parents follow through with treatment recommendations. Unscheduled phone coaching was often used when Lance had difficulty getting to therapy. These calls often focused on helping Mom regulate her emotions, encouraging his parents to use Validate and Cheerlead, and coaching his parents to follow through with the contingency management plan. It is notable that a significant portion of treatment focused on implementing contingency management plan, helping balance dialectical dilemmas in the family, and helping the mother regulate her emotions. At posttreatment and follow-up assessments, Lance no longer met criteria for any diagnoses or SR.

Discussion

This article describes the development and conceptual underpinnings of a novel DBT-SR program and provided two illustrative case examples. DBT-SR is unique in that it uses DBT
strategies to target the significant emotional and behavioral dysregulation observed in youth with SR behavior, even when the primary underlying disorders are internalizing in nature (anxiety, depression). DBT-SR also incorporated web-based conferencing technology to increase dose and ecological validity of its interventions, placing the therapist directly into the trenches in the client’s primary time of need. This pilot trial demonstrated promise in feasibility and acceptability of DBT-SR and raised questions to consider as development continues.

Who Is the Client?

Parents and other family members are almost always involved in any youth-based treatment, whether to provide psychoeducation, reinforce skills at home, provide direct parent management training, or intervene at the family interaction level. Intervening with school refusing youth further highlights this issue due to extreme avoidance and oppositional youth behavior and to the heavy reliance on the parents to act as a coping coach in the home. There is always a potential risk for alliance ruptures or alienating one or more members of the family when multiple family members are involved, particularly when the primary reason for referral is youth school attendance. Group leaders in the skills group were careful to iterate repeatedly that DBT skills were useful for all and reinforced this notion by pushing each attendee, parents and youth, to disclose examples to connect the material to their personal lives. Experientially, this approach worked to engage the parents in the group and many disclosed the personal relevance of the skills. However, the youth appeared to be less engaged in the group over time (there were twice as many adults in the room as youth), and one member dropped out after one group meeting because she preferred youth-only groups. Original multi-family groups of DBT (Miller et al., 2007) included parents and youth in the same group, but future trials of DBT-SR might experiment with having youth-only and parent-only groups.
In individual and WBC sessions, therapists felt they heavily relied on coaching parents to administer DBT interventions with the youth. Many WBC sessions were used to coach parents as the youth refused to come to the computer. The therapist for Lance felt that this alienated the client and challenged their working alliance. This dynamic was particularly exacerbated by the need to strengthen both parents’ skills in coaching sessions. There were multiple instances where Lance re-directed the therapist’s coaching efforts toward the mother, as he believed she needed the most help. The therapist for Ricky felt they were able to balance the structure better, because the youth accepted the need for help more. Future versions of DBT-SR might incorporate techniques from interventions focused on oppositional behavior and parent-youth interactions (e.g., Parent Child Interaction Therapy, Parent Management Therapy) to better accommodate these dynamics.

**What to Do about Attendance Rules?**

Traditional DBT applies strict attendance rules for continued participation in the skills group and individual therapy (“the four miss rule” in standard DBT which states that a client is out of DBT if they miss four individual or group sessions in a row; DBT-A states that a participant can miss up to four individual sessions or groups within the 16-week treatment before they are terminated from treatment). Parent attendance at skills groups and individual sessions was adequate, if not perfect, but youth attendance at skills groups was poor and intermittent in individual/WBC sessions. In considering whether we should apply a hard rule for attendance consistent with the DBT model, we were forced to account for the nature of the problem we were treating. By definition, youth with SR are presenting for treatment because they have difficulties with attendance. This impairment occasionally only affects school attendance, but in general, youth with SR often withdraw, isolate, and become disengaged in activities beyond school
settings. They see friends less, withdraw from extracurricular activities, and refuse family events. We felt it would have been impossible to continue to run the group while adhering to a hard attendance rule (i.e., all families would have been terminated).

To address this, we did encourage parents to attend individual sessions, WBC sessions, and skills groups regardless of youth attendance. We felt this was critical to keep families engaged, increase hopefulness by showing that parents could do something even when youth refused, to impart vital parenting management techniques to help set the stage for DBT skills uptake, and to continue to teach DBT-specific skills. It was also important to send the message that treatment would not stop if the youth refused to participate. Much of the intervention focused on bringing balance to the family structure and parent authority (dialectical dilemmas). By saying parents could attend sessions and continue to learn, even when youth refused to attend, we hoped to send the message that (a) parents can learn skills even without the youth (increase parent self-efficacy), and (b) we will be working to change the family structure even without the youth’s participation (the youth cannot derail change with opposition/avoidance).

In cases of extreme youth absences from group and individual therapy, WBC sessions can provide youth with opportunities to review skills and practice. The two teens described here were more willing to attend WBC sessions than group and individual sessions. In the case of parent non-attendance, we would take a similar approach, allowing the teen to attend groups and individual therapy to the extent that transportation can be arranged (such an approach has been successful in other DBT-A applications; Miller et al., 2007). If all members demonstrate extreme poor attendance, the therapist might work with school liaisons to incentivize and problem-solve therapy attendance. However, like any outpatient therapy effort, attendance is a minimum requirement at some point. Future efforts might work to develop a school-based DBT-SR
approach for work with families who refuse to attend, or drop out of, outpatient care. Such an approach might involve school personnel more directly (e.g., to conduct WBC sessions).

**But Please Just Leave Me Alone!**

The attendance issue highlights a difference between school refusing youth and teens with borderline personality disorder – the original focus for DBT-A. Attendance rules can often be applied as contingencies successfully with teens with borderline personality characteristics because such youth often value interpersonal connection with their therapists and frequently express need for help and support when in distress (Miller et al., 2007). Coming to skills group and individual sessions is valued, and so contingencies that remove this support can serve as an incentive for attendance and practice of skills. For youth with SR, the opposite seems true. The nature of their emotional/behavioral dysregulation is intense avolition, expressed as avoidance of distress and willfulness against moving in the face of effort. Further research is required to explore how to motivate effort in the face of such willfulness. Self-reports from family and youth indicate that techniques like, mindfulness, opposite action (emotion regulation), and distraction (distress tolerance), may be particularly relevant.

**Incremental Benefit of WBC**

Web based coaching was incorporated to DBT-SR to increase dose and timeliness of contact with youth and parents. Like traditional phone coaching in DBT, it also had the potential function of ensuring generalization of skills to the clients’ natural environment. Results show that each family made ample use of WBC (36 and 41 sessions) and satisfaction ratings suggested they found WBC a uniquely helpful aspect of DBT-SR. Parents, youth, and therapists commented that WBC helped increase morning structure, provided real-time assessment and encouragement/support, and helped youth and parents practice skills at critical times. Thus,
Dialectical Behavior Therapy for School Refusal

WBC seemed to provide unique value that improved generalizability of skill acquisition and a sense of support (being in the trenches).

Issues to consider for future improvement include format and timing of WBC. First, using a fixed web-camera on a laptop or desktop was a good first step, but it also limited access. The youth/parents had to come to the room where the camera was set up or bring the camera (laptop) to them. Future versions might consider using mobile devices (e.g., smartphones or tablets) to allow the parent/youth to talk with the therapist from any room in the house (where Wi-Fi is available). The original set-up was chosen for technical reasons: web-cameras provided standardized high-definition video, and the Cisco Jabber (HIPAA-compliant communication software) and screen capture software (to record the WBC session) were only available for PCs. As camera quality improves on mobile devices and required applications become available, mobile devices may become the preferred method for WBC. Increased mobility would also help make coaching available in settings outside of the home, so that therapist might be able to provide coaching at other critical times (e.g., upon school entry; during school day). However, currently, there is limited availability of mobile video feeds.

Other feasibility issues must be considered as this approach is brought to scale. Most sessions occurred between 6:00 and 7:00 a.m. to make coaching available at the time of most need. However, such intensive daily clinical interventions at this early time of day could easily lead to clinician burnout. The initial conceptualization of this tool was to provide a feasible alternative to making home visits. Compared to this option, WBC is more feasible by removing travel time and permitting the possibility of scheduling multiple coaching sessions in the same morning. However, its long-term sustainability would need to be examined as a therapist sees more than one SR client at a time. If a therapist were to attempt to see any number of clients with
SR, she or he would likely have to consider shifting her/his schedule to accommodate the necessity of early-morning coaching.

**Conclusions and Future Directions**

This pilot study demonstrated reasonable “proof of concept” that DBT could be applied to SR-specific concerns, that a DBT-SR group could be run with reasonable feasibility and acceptability, and that the WBC component could add incremental benefit to traditional in-person sessions. Considerable development remains as two of the invited families dropped out of treatment within the first two meetings, raising questions about the appeal of DBT-SR, the particular challenge that exists in recruiting youth with SR behavior, or both. Future efforts will want to explore techniques to improve motivation and engagement in cases of severe attendance problems and lack of parent involvement. Further development of WBC is also encouraged to take advantage of ever-changing advances in technology. The reach of DBT-SR might also be re-considered as it was currently designed for anxiety and mixed forms of SR and not severe conduct problems. Future research might consider incorporating greater use of contingency management, parent management, and anger control techniques to address mild-to-moderate conduct problems. In contrast, SR may result from peer victimization and bullying in schools. In these cases, specific modules might be incorporated to help build protective social networks and navigate school mediation between affected parties. Such extensions of DBT-SR may benefit from greater involvement of teachers and schools (e.g., teaching school staff DBT skills; school staff conducting WBC sessions). As it stands, DBT-SR presents a novel approach to a vexing problem and deserves further development and testing to establish its efficacy and potential reach.
Footnotes

1 The names and some demographic details of both youth were changed to protect confidentiality.
References


### Table 1.
**DBT Strategies and Skills in Traditional DBT-A and DBT-SR**

<table>
<thead>
<tr>
<th>DBT-A Treatment Strategy</th>
<th>Traditional DBT-A</th>
<th>DBT-SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Devil’s Advocate</td>
<td>Used to gather a commitment to treatment and to not commit suicide or self-injure for the duration of the treatment program.</td>
<td>Used to gather a commitment to fully participating in the program, including eventually re-entering school full time.</td>
</tr>
<tr>
<td>2 Diary Card</td>
<td>Used primarily to track daily emotions, urges to self-injure, urges to abuse substances, intensity of suicidal ideation, and use of skills.</td>
<td>Used primarily to track daily emotions, urges to refuse school, classes/days of school missed, tardiness to school, and use of skills.</td>
</tr>
<tr>
<td>3 Including parents in treatment</td>
<td>Parents are included in individual sessions and phone consultation as needed, and are included in weekly multi-family groups. Specific treatment strategies for conducting family sessions are used including family behavioral analysis and addressing dialectical dilemmas. Parent coaching calls often involve using validation to help parents regulate their own emotions to then address youth crises.</td>
<td>WBC and individual sessions may include parents more intensively to implement contingency management plans at home. WBC and phone coaching sessions also focus on improving parenting skills through helping to regulate parent emotions and coaching them to use skills effectively in the moment with youth.</td>
</tr>
<tr>
<td>4 Out-of-Session Skills Coaching</td>
<td>Individual, typically unplanned phone coaching used as-needed to generalize DBT skills. Separate skills coaches available for both parents and youth. Focused on applying DBT skills to real-life situations as WBC with one therapist using videoconferencing as planned, in the mornings, and may involve combinations of family members. Also involves (setting up) pre-planned</td>
<td></td>
</tr>
</tbody>
</table>
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they arise. exposures, and applying DBT skills to these exposure situations.

5 Coaching with Family Members

Typically assign a separate therapist to conduct phone coaching with family members. The same therapist conducts WBC with the youth and parents.

6 Environmental Intervention and Consultation-to-the-Patient Case Management Strategies

Consultation-to-the-Patient used more so than Environmental Intervention in order to increase youth's ability to advocate for themselves and to reduce splitting between individuals interacting with youth who have BPD traits. Environmental Intervention used more in order to consult with school personnel and parents on behalf of the youth. Consultation-to-the-Patient increased as youth is encouraged to have more autonomy.

<table>
<thead>
<tr>
<th>DBT-A Skill</th>
<th>Traditional DBT-A</th>
<th>DBT-SR</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 Dialectical Dilemmas-Middle Path skill</td>
<td>Used in case conceptualization to help create secondary targets for treatment. Also taught in the “Middle Path” module in skills group. Taught as a part of the Walking the Middle Path skills and discussed in individual sessions with youth and parents to help facilitate dialectical thinking.</td>
<td></td>
</tr>
<tr>
<td>2 Behaviorism-Middle Path skills</td>
<td>Teaching parents to closely-examine their own behavior for inadvertent positive reinforcement of suicidal behavior and missed opportunities to reinforce or inadvertent punishment of adaptive behaviors. Behaviorism more focused on helping parents implement daily, pre-planned positive reinforcement contingent on desired behavior (e.g., school attendance and its approximations).</td>
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<td></td>
<td>Dialectical Behavior Therapy for School Refusal</td>
<td>p. 39</td>
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<tr>
<td>---</td>
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<td>------</td>
</tr>
<tr>
<td>3 Validate and Cheerlead-Middle Path skills</td>
<td>Teaches both parents and youth to validate each other and to self-validate, which is often a deficit in families with youth who have BPD traits (i.e., the invalidating environment transacting with emotional vulnerability).</td>
<td>Used strategically as a skill for parents to validate youth’s experience in the moment when exhibiting SR behaviors and to cheerlead or encourage them to accomplish an effective goal instead. Used also for youth to self-validate their emotional/physical distress in the moment.</td>
</tr>
<tr>
<td>4 Distract- Distress Tolerance skill</td>
<td>Used as a skill to help youth not engage in impulsive behaviors, such as self-injury or suicidal threats/behaviors.</td>
<td>Used as a skill to help youth not engage in SR behaviors, such as staying in bed, refusing to go to therapy sessions, or driving to school.</td>
</tr>
<tr>
<td>5 Opposite Action- Emotion Regulation skill</td>
<td>Used as a skill to help reduce the intensity of an unwanted emotion, such as anger, fear, or shame, by acting the opposite of the emotional urge (e.g., youth feels shame and wants to hide and instead appears confident and open with others).</td>
<td>Used as a skill more specifically to help reduce the intensity of the distress that is experienced by going to school, by doing the opposite action (e.g., listening to music the youth enjoys when waking up in the morning to reduce depressed mood and increase motivation).</td>
</tr>
</tbody>
</table>
Table 2.
Diagnosis, Impairment, and School Absences at Pretreatment, Posttreatment, and 4-month Follow Up.

<table>
<thead>
<tr>
<th>Youth</th>
<th>Sex</th>
<th>Diagnoses</th>
<th>Pre-Tx CSR</th>
<th>Post-Tx CSR</th>
<th>Follow up CSR</th>
<th>Pre-Tx CGI-S</th>
<th>Post-Tx CGI-S</th>
<th>Follow up CGI-S</th>
<th>Pre-Tx absent rate</th>
<th>Post-Tx absent rate</th>
<th>Follow up absent rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>M</td>
<td>School Refusal</td>
<td>6</td>
<td>6</td>
<td>(0)</td>
<td>5</td>
<td>4</td>
<td>1</td>
<td>13 (50%)</td>
<td>8 (38.1%)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Major Depression</td>
<td>5</td>
<td>(0)</td>
<td>(0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generalized Anxiety Disorder</td>
<td>4</td>
<td>(0)</td>
<td>(0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>M</td>
<td>School Refusal</td>
<td>7</td>
<td>(3)</td>
<td>(3)</td>
<td>5</td>
<td>3</td>
<td>2</td>
<td>12 (100%)</td>
<td>2 (8.7%)</td>
<td>0</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Generalized Anxiety Disorder</td>
<td>6</td>
<td>(0)</td>
<td>(0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Social Phobia</td>
<td>4</td>
<td>(0)</td>
<td>(0)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
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</tbody>
</table>

Note: CSR=ADIS-IV Clinician Severity Rating where CSR ≥ 4 is threshold for clinical diagnosis, CSR in parentheses are subclinical; CGI-S=Clinical Global Impression-Severity Rating; Absent rate was calculated by listing number and percentage of days absent in the month prior to assessment.
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Highlights

- School refusal is a clinically complex and impairing problem that affects diverse youth. Few effective interventions have been developed to address these concerns.

- Existing treatment approaches for school refusal may have limitations in both the treatment model and delivery system.

- Dialectical Behavior Therapy for School Refusal (DBT-SR) is a novel intervention designed to address the emotional and behavioral dysregulation mechanisms that maintain school refusal behavior. A novel web-based coaching component helps provide “real-time” coaching at the times and in the settings of most need.

- An open pilot trial suggested DBT-SR is potentially feasible and acceptable and deserves further evaluation.