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# Modular Treatment for Children and Adolescents With Problematic School Absenteeism: Development and Description of a Program in Germany

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*Problematic school absenteeism is defined as absence from school occurring with a clinical-level mental disorder. It represents a higher-order term for school refusal, school truancy, and the combination thereof and is associated with an increased risk for school dropout, prolonged mental disorders, and unemployment. This article describes the manualized modular treatment of problematic school absenteeism (MT) by a multiprofessional team. The manual was developed to target a broad spectrum of mental disorders characterized by internalizing but also externalizing behavior. The therapeutic focus is on the reintegration into school and on the cognitive behavioral treatment of the mental disorder. The MT is based on a multilevel model of problematic school absenteeism. The treatment is informed by an extensive case-conceptualization and addresses motivational aspects by offering a low-threshold therapeutic design and motivational interviewing. Core interventions are represented in four modules: cognitive behavioral therapy, family counseling, school counseling, and a psychoeducational physical exercise program. A case vignette provides an illustration of the treatment and the specific graduated approach for school reintegration. The current modular approach is discussed in relation to other cognitive-behavioral manuals targeting a broad spectrum of mental disorders or school refusal.*

School absenteeism, when defined as unexcused nonattendance at school for at least several hours, is reported by 10%–60% of secondary school youth in Germany (Weiss, 2007). Between 5%–10% of German students miss school, unexcused, for more than 5 days per school year (Jans & Warnke, 2004; Wagner, Dunkake, & Weiss, 2004). Prolonged school absenteeism is related to an increased risk of failing school, later unemployment, and mental disorders (Balfanz & Byrnes, 2012; Kearney, 2008).

"Problematic school absenteeism" is used as a higher-order term for school refusal, school truancy, and the combination thereof. The term "school refusal" refers to youths who miss school because of anxiety and/or other signs of emotional distress (e.g., depressive symptoms or somatic complaints; Knollmann et al., 2010). The term "truancy" describes children or adolescents who deliberately do not attend school and whose parents initially have no knowledge of the child's or adolescent's nonattendance (Kearney, 2008). This behavior is often but not necessarily associated with externalizing symptoms and conduct disorders (Egger, Costello, & Angold, 2003; Maynard, Salas-Wright, Vaughn, & Peters, 2012). A mixed group of youths with both truancy and school refusal has been identified in various studies (e.g., Egger et al., 2003; Knollmann, Reissner, Kiessling, & Hebebrand, 2013).

In the current paper, "problematic school absenteeism" is used to refer to school absenteeism associated with a mental disorder. This is because the intervention described in the paper was developed for youths who present with mental health problems to a psychiatric setting. Other authors have similarly referred to problematic school absenteeism as one or more periods of absence from school, associated with symptoms of mental disorders (Knollmann et al., 2010; Lehmkuhl & Lehmkuhl, 2004). The prevalence of mental disorders in students with school absenteeism depends on the particular sample. In a community-based sample, mental disorder was reported among 25% of school refusers and 25% of truants (Egger et al., 2003). Eighty-eight percent of youth regarded as mixed school refusers (i.e., school refusal and truancy) suffered from a mental disorder.

The authors of the current paper recently developed and tested a Modular Manual for the Treatment of

*Keywords*: problematic school absenteeism; school refusal; school truancy; cognitive behavioral therapy; motivational interviewing

Problematic School Absenteeism (MT; Reissner, Hebebrand, & Knollmann, 2015). MT is a manual-based cognitive behavioral treatment (CBT) aimed at addressing both the attendance issues and mental health problems associated with school absenteeism. The development of MT was inspired by the needs of children and adolescents attending an outpatient unit for problematic school absenteeism, located in the Department of Child and Adolescent Psychiatry at the University Clinic of Essen in Germany. Essen is the ninth largest city in Germany, with a population of 590,000. The number of outpatients treated each year is about 2,200. Of these, approximately 150 receive care in the specialized outpatient unit for problematic school absenteeism. Youth participating in the specialized unit have been found to display school refusal (54%), school truancy (29%), or mixed school refusal and truancy (17%; Knollmann, al-Mouhtasseb, & Hebebrand, 2009). Consequently, the MT was developed to address youth displaying all three types of problematic school absenteeism.

The effectiveness of the MT was previously reported by Reissner, Jost, et al. (2015). It was tested in a randomized controlled trial (RCT) conducted with 112 children and adolescents with problematic school absenteeism. Of these, 60% presented with school refusal, 15% with truancy, and 25% with mixed school refusal and truancy. The subjects were randomly allocated to the MT-condition or to treatment as usual (TAU), which involved outpatient treatment by 1 of 10 collaborating child and adolescent psychiatrists. During the following 12 months the proportion of regular school attenders increased to 66% in the MT condition and 61% in the TAU condition, with no significant between-group difference. These results are in line with previous studies which showed that CBT and other psychosocial interventions for school refusal resulted in regular school attendance of at least 60%–65% of youth, depending on the definition of "regular" (e.g., $\geq$ 90% or $\geq$ 95% attendance rate; e.g., Heyne et al., 2002; Last, Hansen, & Franco, 1998). Reissner, Jost, et al. (2015) also found that depressive symptoms were significantly lower among MT patients 1 year after study inclusion. The adjusted treatment costs were nominally lower for the MT condition compared to TAU, but there was no significant difference (Weschenfelder et al., 2018). Considering the outcomes, MT may help therapists new to the field to implement a structured treatment process for youth with problematic school absenteeism.

The purpose of the current paper is to provide therapists with information about the development and delivery of the manual-based modular treatment. After describing the guiding principles for MT, we describe the multidisciplinary approach inherent to the treatment, our multilevel model of problematic absenteeism, the focus on motivational work, and the aims of the four treatment modules. We then provide details about the delivery of each module, followed by an illustrative case vignette.

## Treatment Development

### Guiding Principles

In order to develop the MT, we primarily consulted meta-analyses, reviews, and RCTs on CBT for school refusal. A meta-analysis and a review provide support for the effectiveness of behavioral and cognitive strategies in improving school attendance rates (Maynard et al., 2015; Pina, Zerr, Gonzales, & Ortiz, 2009). Some of the strategies described in RCTs targeting youth with school refusal are the modification of negative self-talk during anxiety situations and training in exposure to achieve gradual return to school (e.g., Heyne et al., 2002; King et al., 1998). Additional interventions include behavior management strategies for parents and school personnel (e.g., Heyne et al., 2002). In Heyne, Sauter, van Widenfelt, Vermeiren, and Westenberg's (2011) report on the modular "@School Program," sessions were also conducted jointly with parents and youth to improve family communication and problem-solving. Our review of the literature on CBT for school refusal suggested that CBT helps reduce the psychopathology related to school refusal, alongside its impact on school attendance. In order to address the group of youths with truancy, and the group with mixed school refusal and truancy, we included interventions targeting truancy-related behavior (see Module 1 – Cognitive Behavioral Therapy).

In developing the MT we focused on five main goals. First, the treatment should target a broad spectrum of mental disorders. Second, therapy should target the mental disorder *and* reintegration to school. Third, because problematic school absenteeism is a multifaceted problem, treatment should be modular. Thus, we included four modules: (1) CBT; (2) family counseling; (3) school counseling; and (4) psychoeducational physical exercise, where physical training is blended with a focus on team-building, social competency, and motivation. Modules can be flexibly employed according to the needs of the individual and their family. Fourth, the treatment should be transferable to other outpatient psychiatric services for children and adolescents. Fifth, treatment is structured to facilitate the operationalization and evaluation of the therapeutic process and its cost-effectiveness.

### Emphasizing a Multidisciplinary Approach

The MT was designed by members of a multidisciplinary team, each responsible for the development and delivery of a particular module. CBT was developed by psychotherapists and psychiatrists, family counseling (FC) was developed by psychiatric nurses, school counseling (SC) was developed by teachers for children with special

needs, and the psychoeducational physical exercise program (PE) was developed by a sports scientist.

It was decided that treatment delivery would be coordinated and supervised by the CBT therapist as case manager for the patient and family. CBT was regarded as the central module, its delivery informed by an extensive case conceptualization. It includes a graduated approach to dealing with problematic school absenteeism, via *in vivo* exposure. Additional interventions from the FC, SC, and PE modules enrich the treatment by drawing attention to family-, school-, and peer-related aspects of problematic school absenteeism. The therapeutic progress of each patient is discussed during regular case conferences involving the psychotherapist, the psychiatric nurse, the teacher, and the sports scientist.

## Drawing on a Multilevel Model of Problematic School Absenteeism

There were various reasons for employing a multilevel model of problematic school absenteeism. First, the model was used to specify the target group likely to benefit from the treatment. It integrates three different subtypes of problematic school absenteeism (school refusal, school truancy, and the mixed group) as well as behavioral, functional, and diagnosis-related conceptualizations of problematic school absenteeism (Figure 1). Second, problematic school absenteeism is associated with three key areas of the youth´s life: the individual´s psychological problems, the psychosocial environment at school, and the family environment. Often, these three areas are also related to the associated mental disorder. Third, the multilevel model fosters a shared understanding of problematic school absenteeism among the members of the multidisciplinary treatment team. It provides an interdisciplinary framework for communication, conceptualization, and intervention delivered by teachers, social workers, psychiatric nurses, psychotherapists or psychiatrists, and other professionals working to reintegrate the child into school. In short, the multilevel model creates a shared vision of what is to be achieved. It can also be used for communicating with parents and patients about problematic school absenteeism.

The model comprises four levels pertaining to different educational, psychotherapeutic, and psychiatric concepts. The first level—the Behavioral Level—describes dysfunctional symptoms and behaviors associated with problematic school absenteeism. It associates the concept of school refusal with internalizing symptoms (i.e., anxiety, depression, social phobia), truancy with externalizing symptoms (i.e., hyperkinetic behavior, conduct problems, oppositional-defiant behavior), and the mixed subtype with internalizing and externalizing symptoms.

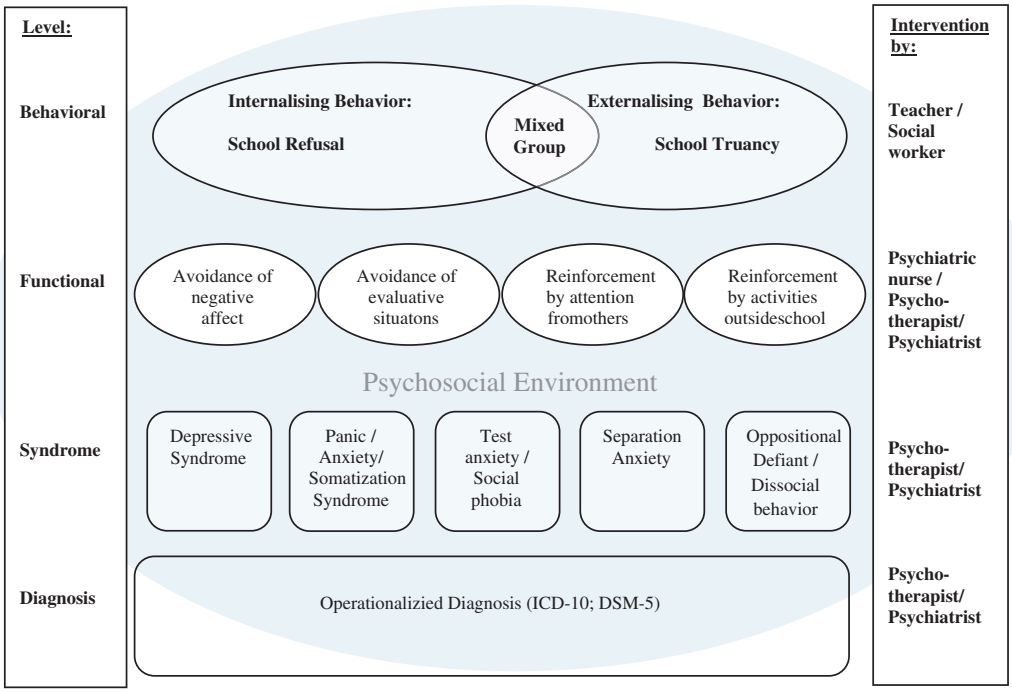


**Figure 1.** Multilevel model of problematic school absenteeism. Adapted from *Beratung und Therapie bei schulvermeidendem Verhalten. Multimodale Interventionen für psychisch belastete Schulvermeider – das Essener Manual* (p. 13) by V. Reissner, J. Hebebrand, & M. Knollmann (Eds.), 2015, Stuttgart: Kohlhammer. Copyright 2015 by Kohlhammer. Adapted with permission.

The Functional Level is the second level, focusing on the function of problematic school absenteeism as suggested by Kearney (2006, 2007). Accordingly, problematic school absenteeism may have four reinforcing functions: (a) avoidance of school-related stimuli that cause negative affect, such as depression or anxiety; (b) avoidance of aversive social or evaluative situations (e.g., peer interaction or exams); (c) reinforcement by attention from significant others; and (d) reinforcement via pleasant activities outside of school. The function of the problematic school absenteeism is considered during the therapist's preparation of the case conceptualization. It improves the therapist's and the team's understanding of the reasons for school nonattendance.

The third level—the Syndrome Level—is closely connected with the second level and it refers to five common constellations of mental symptoms: (a) "depressive syndrome"; (b) "panic, anxiety, somatization syndrome," usually associated with the avoidance of school-related stimuli that induce negative affect; (c) "test anxiety and social phobia syndrome," related to the avoidance of aversive social or evaluative situations; (d) "separation anxiety syndrome," characteristic of refusal to go to school in order to stay with the parents due to separation anxiety, and it often pertains to younger children; and (e) "oppositional-defiant and dissocial behavior syndrome," which entails reinforcement by positively experienced activities outside of school such as spending time with peers, computer games, or substance use. These common syndromes can be easily identified by counselors, teachers, or other team members not familiar with diagnostic manuals such as the International Classification of Diseases (ICD-10; World Health Organization, 1990) or the Diagnostic and Statistical Manual (DSM-5; American Psychiatric Association, 2013).

The fourth level of the model—the Diagnostic Level—describes the mental disorder diagnosed according to the ICD-10 or DSM-5. The diagnosis of a mental disorder according to ICD-10 or DSM-5 facilitates the assessment and treatment of the disorder for the psychotherapist.

### Fostering a Motivational Therapeutic Attitude

A youth's poor motivation to attend school exacerbated by the presence of a mental disorder was a key reason for us to employ a low-threshold therapeutic attitude based on motivational interviewing (MI). Members of the treatment team shared the notion that treatment should be offered even to those youths who showed very low intrinsic motivation to change, often due to low confidence, relapse into dysfunctional behavior, and/or ambivalence. It was decided that the minimal prerequisite for the initiation of treatment was that at least one parent expressed the wish to collaborate.

Several other reasons supported the use of MI as a therapeutic approach. First, risk factors for problematic school absenteeism include transitions (e.g., between classes, grades, or schools) and discontinuities that arise due to school vacations or absence due to somatic disorders (Garrison, 2006; Knollmann et al., 2010). In the face of transitions and discontinuities there may be an increase in anxiety, and a decrease in self-esteem and self-efficacy, even within a few days, resulting in problematic school absenteeism. Developing treatment goals and building up confidence to change is a major aim of MI. Second, ambivalence about returning to school or attending treatment is seen in children and adolescents who experience pressure from teachers, parents, and others to attend school or treatment sessions (Persson, Hagquist, & Michelson, 2017). MI aims to induce change talk; the client is encouraged to analyze the advantages and disadvantages of behavioral change or the status quo. Creating a sense of discrepancy between the current situation of nonattendance at school and broader life goals and values such as entering vocational training (Apodaca & Longabaugh, 2009) may help the client to recognize the advantages of changing (i.e., engaging in treatment and/or returning to school). Third, clinical experience and treatment outcome studies indicate that a successful school reintegration is not always sustained (e.g., Walter et al., 2010). Young people may relapse into dysfunctional behavior. In the same way that MI reduces relapse following treatment for substance use disorders, it might reduce relapse among youths with problematic school absenteeism (Islam, Topp, Conigrave, & Day, 2013; Rachlis, Kerr, Montaner, & Wood, 2009). The therapeutic approach of MI (Miller & Rollnick, 1991) can be used to address these issues. MI can also be combined with other therapeutic approaches such as CBT (Angus & Kagan, 2009). For example, pretreatment MI sessions were successfully used by Kertes, Westra, Angus, and Marcus (2011) to improve CBT response rates among patients with generalized anxiety disorders.

MI was implemented in each of the four modules of the MT as a reminder to check the youth's motivational status, enhance intrinsic motivation, and avoid resistance. Motivational status was assessed at the beginning of each therapy session by checking the importance of behavioral change for the patient and their level of confidence to achieve goals. MI interventions for the different stages of change were specified for youths, summarized in so-called "tool-boxes." In addition, patient motivation was considered during case conceptualization and reevaluated during case conferences held over the course of treatment. During the case conferences the motivational stage associated with school return or with other treatment goals was assessed based on the model of Prochaska et al. (1992).

### Designing the Modules

All modules were developed and refined in an ongoing team-based process during the first implementation phase (March 2009 to December 2010). Members responsible for each module developed their specific interventions on the basis of brainstorm sessions, their clinical experience, and a literature review. The interventions were discussed and then written up for the manual. For all modules, the delivery of interventions is based on specific indications described in the manual. These indications help professionals decide which treatment modules will be introduced to the family, alongside the CBT module which is used in all cases. Within each module, there are also indications as to which interventions are appropriate. The feasibility of the preliminary manual was tested by implementing it in routine clinical practice. Ongoing feedback obtained during clinical work informed the process of refining the manual's structure and the interventions.

Because CBT interventions have been shown to be effective in the treatment of problematic school absenteeism, the CBT module was the central treatment module. It includes a multiperspective case conceptualization to target different types of mental disorders associated with problematic school absenteeism. Various disorder-specific CBT interventions from existing manuals were implemented (see Module 1—Cognitive Behavioral Therapy). In addition, specific cognitive behavioral interventions targeting problematic school absenteeism were developed based on clinical experience. An initial idea was to solely conduct group-based CBT to reduce treatment costs. This was not pursued because case-specific crises occurring at the beginning of treatment and throughout treatment necessitated individual therapy. Thus, CBT was provided individually as well as in group-based sessions.

Family counseling is deemed to be an essential aspect of treatment for youth with problematic school absenteeism (e.g., Bryce & Baird, 1986; Heyne et al., 2008). On the basis of previous clinical experience with families of children not motivated to seek help from an outpatient service, the MT family counselors tested the implementation of home visits. This procedure reduced the threshold for patients to enter therapy and so it was included in the FC module.

The SC module was developed because of youth's or parents' problems with school as an institution, and confusion about which school or vocational career to pursue. Interventions in the SC module include communication with school personnel about mental health problems, and mediation between teachers and family members.

The rationale for adopting a psychoeducational physical exercise program in the form of the PE module was twofold. First, studies with adolescents and adults indicate an improvement in psychological well-being among those with mental disorders, after they have engaged in physical fitness (e.g., Knubben et al., 2007; Nabkasorn et al., 2006). Second, the setting used for group training allows the trainer to implement therapeutic interventions that help improve aspects of the youth's functioning such as social skills and self-efficacy.

The referral of cases with severe psychopathology and chronic problematic school absenteeism (i.e., nonattendance for more than a year) led us to abandon an initial plan of offering a set number of therapeutic sessions. Instead, MT is an open-ended therapeutic process. The manual simply proposes that treatment be terminated 6 weeks after the achievement of regular school attendance ($\geq$ 95% school attendance). To prevent relapse, a system was established to facilitate early detection of dysfunctional behavior and school absenteeism.

## Treatment Delivery

### Module 1—Cognitive Behavioral Therapy

Each week there are one or two CBT sessions of an hour, whether in group or individual format. On average, youths take part in 16 CBT sessions. These sessions span three therapeutic stages: case conceptualization, treatment planning, and active treatment in individual and group sessions (Table 1).

In the first phase—*case conceptualization*—the therapist is focused on building a therapeutic relationship with the young person and his or her parents. A thorough assessment of both the mental disorder and the problematic school absenteeism is initiated by the CBT therapist, making use of structured interviews and psychological testing. Attention is also given to the development of treatment goals with the patient and his parents, and to building motivation to change dysfunctional behavior. The average duration of the phase is two to three sessions.

The case manager presents the information derived during this phase at a multidisciplinary case conference attended by professionals responsible for the other three modules. The youth and the parents are not present. A structured presentation includes the case history, diagnoses, the function of the problematic school absenteeism according to Kearney (2006, 2007), a cognitive behavioral micro- and macro-analysis with regard to problematic school absenteeism, psychosocial functioning, motivational status, and plan analysis (Caspar, 2007; Kramer, Berger, & Caspar, 2009). Plan analysis seeks to explain the patient's behavioral patterns according to his conscious or unconscious plans and higher-order goals or needs (e.g., "avoid contacts with classmates"). Subsequently, the treatment team discusses and develops an individual problem conceptualization which is the basis for a plan for the forthcoming treatment. This plan comprises the definition of the dysfunctional behavior, its reinforcing

Table 1
MT Modules: Indications, Structure, and Content

| | |
|---|---|
| **Cognitive Behavioral Therapy** | |
| Indications | Problematic school absenteeism plus mental disorder (applicable in all cases). |
| Frequency/Setting | Up to two sessions per week; Open-ended therapy; Individual therapy and group sessions; CBT-therapist as case manager. |
| Content | First phase—case conceptualization: Assessment of mental disorder and problematic school absenteeism; Promoting the motivation to change; Multi-disciplinary case conference with development of a solution-focused professional treatment plan, including decisions on the implementation of other modules (after session four).<br>Second phase—treatment planning with the family: Conceptualization and further development of the treatment plan with the youth and his/her parents, including a graduated A-B-C-plan.<br>Third phase—active treatment: Graduated in-vivo-exposure; disorder-specific interventions. |
| **Family Counselling** | |
| Indications | Family-based reinforcement of school avoidance (e.g., anxious parent encouraging child to stay at home). |
| Frequency/Setting | One session per week; Home visits; Group-based psychoeducational program for parents. |
| Content | Establishing/communicating family rules; Introduction of positive reinforcement behavior plans; Support during in-vivo-exposures. |
| **School Counselling** | |
| Indications | Learning problems, dysfunctional teacher-student or teacher-parent interaction, change of school. |
| Frequency/Setting | One individual session per week; At least one contact with the teacher at school. |
| Content | Educational advice for parents; Psychoeducation for teachers; Developing learning plans and learning strategies with the youth; Counselling with regard to school or vocational career. |
| **Psychoeducational Physical Exercise Program** | |
| Indications | All youth participate in at least three sessions. |
| Frequency/Setting | After three obligatory sessions, participation in nine additional sessions is voluntary; Group setting. |
| Content | Physical training blended with team-building, enhancing self-efficacy, social support, motivational self-talk, mindfulness. |

*Note.* MT = Modular Manual for the Treatment of Problematic School Absenteeism.

factors, and a specification of therapeutic aims and procedures. It also includes decisions about whether interventions from other treatment modules are indicated.

The second phase—*treatment planning with the family*—involves meeting with the youth and his parents to develop a joint conceptualization of the problem and a joint treatment plan. The case conceptualization developed by the multidisciplinary team serves as a basis for discussion with the youth and parents, allowing for updates and renegotiation of the conceptualization. Balancing the professionals' plan with the patient´s subjective theories (e.g., his views on "what went wrong at school or at home") is crucial for motivation and continuation of the therapeutic process (Flick, 1998). Solutions are developed based on existing resources, drawing on interventions from Solution Focused Brief Therapy (e.g., looking for previous solutions, looking for exceptions; De Shazer et al., 1986; Gingerich & Eisengrat, 2000). On average, the second phase spans two sessions. Professionals associated with the other relevant MT modules (i.e., FC, SC, and/or PE) are introduced to the family at this stage. Agreement between all therapists, the patient, and the parents about the treatment plan leads to the next treatment phase.

The third phase is *active treatment*, whereby disorder-specific interventions from published treatment manuals are adapted and employed with children and adolescents with problematic school absenteeism. The most prevalent disorders and manuals used are those for depression (Harrington, 2013), social phobia (Stangier, Clark, & Ehlers, 2006), conduct disorders (Petermann, Döpfner, & Schmidt, 2001), and anxiety disorders including test anxiety (Suhr-Dachs & Döpfner, 2005). The heterogeneity of mental disorders in youths with problematic school absenteeism requires such flexibility. During the active treatment phase, additional group sessions are provided for two age groups (above or below age 14). Individual and group sessions focus on topics such as: motivation; anxiety; the relationship between thoughts, feelings and behavior; training of social and emotional competencies; and self-management. The group sessions for children between 10 and 13 years are highly structured. In contrast, the sessions for youths from 14 years onwards are less structured as they give youth the opportunity to introduce their own issues related to the main topics (Fiedler, 1996). Parents do not participate in the CBT group sessions.

An individualized graduated approach for school reintegration represents a key structural element within

the treatment. The graduated approach includes the patient´s ideas with regard to school reintegration. If "Plan A" has failed (e.g., the patient´s wish to show his parents his ability to return to school without help and within a given time), then "Plan B" is initiated. Plan B involves increased therapeutic help. For example, the patient agrees to continue outpatient treatment and attendance at a special school for youths with emotional and behavioral disorders for a specified time period. The next goal is reintegration into regular school. In case of failure to attend the special school or in the case that the subsequent integration into regular school fails, "Plan C" comes into effect, which consists of inpatient treatment. This graduated A-B-C plan is developed at the beginning of the treatment together with the patient and his parents in order to provide a framework. It signals that reintegration to school is the goal because schooling is compulsory, but it is the patient´s choice as to how this is achieved.

The graduated approach includes decision-making about a change of school as well as precise planning of the "comeback-scenario" (the first day back at school) in accordance with the ideas of the patient, teacher, and parents. After preparatory graduated in vivo exposure (e.g., making one's way to school, entering the empty school building, visiting classes on the first day back at school), the duration of daily exposures to school is continuously increased. "Time-outs" may be agreed upon to facilitate reintegration (i.e., the youth is allowed to stay away from certain anxiety-provoking lessons he is not yet able to participate in). The average duration of phase three is 12 sessions.

Therapeutic progress is monitored weekly by the case manager. All professionals jointly discuss therapeutic progress during a major follow-up case conference (60-minute duration) about 9 weeks after the case conceptualization. Mini case conferences (30-minute duration) with the team are held as often as needed, and at least once every 2 weeks. Both types of conferences are structured by a standardized agenda (i.e., presentation of the course of the therapy, achievement of therapeutic goals, coordination of interventions). If necessary, pharmacotherapy is applied according to disorder-specific treatment guidelines.

### Module 2—Family Counseling

Family-based reinforcement of problematic school absenteeism is the main indication for this module. Typical examples of family-based reinforcement include: poor parental educational abilities and family communication; insufficient parental support for children with internalizing disorders; dysfunctional, neglectful parenting; and vague rules in families of youth with externalizing disorders.

The FC module includes several supportive and educational interventions for the child together with the parents (Table 1). For instance, in some cases family rules may be dysfunctional or nontransparent, which in turn may reinforce problematic school absenteeism. All members of the family are involved in a discussion about explicit and implicit family rules (e.g., about daily morning routines). Topics for discussion may include the necessity of rules, different views of family members, and the consequences for breaking family rules. Once all family members consent to a set of rules, these are written down. The family counselor leads the discussions and helps the family transfer the outcomes of the discussions to everyday life.

If the youth has problems walking or riding to school, this is an indication for the FC counselor to implement the strategy "coping with going to school." This strategy includes two interventions, depending on the type of problematic school absenteeism (school refusal or school truancy). In the case of school refusal–related anxiety about going to school, the intervention may incorporate *in vivo* exposure therapy delivered by the counselor of the FC module, in close cooperation with the case manager. The intervention is terminated when the youth's anxiety levels are significantly reduced. In the case of school truancy–related behavior, the intervention may include building the youth´s motivation to return to school, structuring his day, and/or introducing positive or negative consequences to foster school attendance. FC sessions are usually 1 hour per week. On average, youth and their parents take part in six FC sessions.

It is often easier for youth and families to engage in the FC module when therapists make home visits. Home visits are indicated if the patient is too anxious to leave his home (e.g., severe phobia) or when he refuses to see the therapist at the outpatient department (e.g., conduct disorder). FC then focuses on improving communication with respect to family rules (e.g., daily routines) and supporting the appropriate parenting role (e.g., positive reinforcement to promote adherence to family rules or to reward the youth for the reduction of anxiety-related avoidant behavior). Home visits are necessary in approximately 15% of cases.

The FC module includes a psychoeducational program delivered in group sessions with the parents only. The family counseling team provides psychoeducation about problematic school absenteeism and adaptive parenting skills. The group sessions are recommended in all cases, and they may be particularly helpful for parents whose children are under 10 years of age (Warnke, Beck, & Hemminger, 2007). The number of FC group sessions was set at 9, based on clinical experience which indicated that major topics could be adequately addressed in this time.

### Module 3—School Counseling

The main indications for this module include learning problems and the wish or need for a change of school class, grade, or type of school (Table 1). Additional

indications are the experience of bullying or problems with teachers at school (e.g., the teacher is not familiar with the disorder-related problems of the youth; parents and child blame the teacher for dysfunctional behavior at school).

SC is delivered to both the youth and the parent(s) together. It is delivered once a week by a teacher specialized in teaching students with mental disorders. Parents and youth take part in approximately four counseling sessions delivered by the teacher. Educational advice is provided to youths after a thorough analysis of their learning and social behaviors. To provide this advice, home visits may be appropriate. The intervention may encompass the provision of a detailed, individually tailored curriculum for students with special needs (Eggert, 2000; Ledl, 1994). On at least one occasion, the SC counselor contacts the youth´s teacher at the regular school in order to improve the communication between the familiy and the school. If required, the teacher(s) at the regular school are helped to understand the youth's mental health problems. For youth with a high risk of school dropout, vocational training is provided.

### Module 4—Psychoeducational Physical Exercise Program (PE)

The PE module includes 12 training sessions of 90 minutes, once per week. It is offered to all youth at the beginning of the active treatment phase of the CBT module. After three obligatory sessions the youth can decide whether to continue. The training includes the use of computer-based sports games (e.g., volleyball, tennis, boxing, general fitness), which facilitate physical activity and are often attractive for youth with problematic school absenteeism. In later training sessions virtual reality is replaced with outdoor games or other real-world sports activities. The physical training is blended with team-building tasks, enhancing self-efficacy (Hermann & Eberspächer, 1994), motivational self-talk (Stoll, 2010), as well as social support, social competencies, relaxation techniques, and mindfulness (Linehan, 1996). On average the youths participates in six PE sessions.

## Case Vignette

### Background

M.[1] was a 15-year-old girl in ninth grade (i.e., the fifth year after transition to high school). She lived with her mother and a younger sister (6 years). She stopped attending school about 3 months prior to her first visit to the outpatient unit at Essen. At elementary school she had problems participating in class due to separation anxiety, which led to intermittent day-long absences from school, especially on Mondays, due to somatic complaints. In the year prior to referral to the outpatient unit she had intermittently avoided school for a total of 4 months because she felt bullied. Her family had not sought psychotherapeutic help at that time. In light of these difficulties, she changed to another school. According to M.: "At first, everything was fine there, but then it started all over again. The other students excluded me from their activities and during the breaks no one talked with me. The stomach-ache started in the evening, and when I woke up, it was even worse. After I was unable to go to school for two weeks, I stopped trying all together, because I was afraid that everyone would look at me and ask me where I had been." M.'s mother reported that M. had become socially withdrawn after the divorce of her parents 2 years earlier. Since then, M. had behaved in an oppositional-defiant manner and at times she was outrightly aggressive at home. M.'s mother described it this way: "When I try to wake her, she curses me and throws things in my direction. She usually wakes up in the afternoon and then spends most of her time in her room watching videos online or playing online games." M. had refused contact with her father because she blamed him for the parents' divorce. Her teacher at the new school reported that M. received average grades in school and that she had not noticed any bullying of M. by her classmates. According to the teacher: "M. is very shy and isn't able to answer when her classmates try to make contact with her. She had one close friend in class, but a few months ago they had a severe conflict, and after that M. started ignoring her former best friend."

### Case Conceptualization and Treatment Planning

Assessment with M. and her mother revealed that M. had been a very shy child ever since kindergarten and that she repeatedly showed signs of separation anxiety. Her mother described herself as a very anxious person, always trying to avoid conflicts with M. by "letting her have her way." Psychological testing with M. revealed an average IQ and supra-threshold depressive symptoms and social anxiety. During *case conceptualization*, the team adopted a developmental psychopathological approach and focused on the relationship between the anxious-depressive symptoms and the dysfunctional interactions between M. and her mother, which seemed to have led to repeated failures regarding the developmental task of establishing stable peer relationships. Factors that were positively reinforcing problematic school absenteeism were sleeping in on weekdays, playing online games, and attention from her mother. Factors that were negatively reinforcing problematic school absenteeism were the avoidance of feelings of guilt and embarrassment

[1] The adolescent ("M.") and her mother provided permission for deidentified case information to be used. Descriptive data have been altered to protect the anonymity of the family.

regarding her classmates, especially her former friend with whom she had experienced an embarrassing situation. M. expressed her motivational ambivalence with regard to returning to school. The indication for the implementation of the FC module was the dysfunctional interactions between mother and daughter. The indication for the implementation of the SC module was the fact that her teacher did not show any insight into M.'s disorder and problems, and she previously unintentionally triggered anxious cognitions in M. Participation in at least three sessions from the PE module was obligatory.

The *treatment planning* with M., her mother, and her teachers included the negotiation and translation of the professional problem model into a joint psychotherapeutic model using *psychoeducation, plan analysis, and MI techniques*. The professional team regarded it as crucial that M. could develop autonomy in her relationship with her mother. Instead of demonstrating autonomy by refusing her mother's attempts to wake her, M. was instructed to regain full responsibility for waking, getting up, and attending school. In turn, her mother agreed to refrain from being involved in M.'s morning routines. Both agreed on rules regarding sleep and online activities, which were established together with the *family counselor* (e.g., getting up at 7:00 A.M.; limiting gaming to a maximum of 2 hours in the afternoon/evening; "no school attendance equals no games"). M. was reluctant to visit school for even 2 or 3 hours before there was a resolution of the conflicts between her and her former best friend and classmates. Given this, the *school reintegration plan* was set up with M., as described next.

### Weeks 1–4: Preparation for Return to School

- Home training for my return to school with the support of the *family counselor*; wake up by myself at 7:00 A.M.; work on school assignments during the morning (the teacher agreed to send these); bed time at 10:00 P.M.
- I will solve the conflict with T. (former best friend) with the support of my *therapist*; I will contact T. via WhatsApp after I work out a strategy; I will meet with T. to apologize, and to address problems regarding T.´s behavior; I will do this in a self-controlled, emotionally appropriate way.
- I will attend individual and *group therapy* to learn strategies to cope with my stomach pain, to be more active, and to solve interpersonal problems.
- I will talk with my teacher with the help of the *school counselor*: What kind of support do I need when I reenter school? What will I say? What will I answer when my classmates ask me where I have been? I will practice this with my *therapist*.

### Week 5: Return to School

- I will start to attend school again; the *family counselor* will accompany me on my way to school during my first two school days. The first week I may leave school after the second lesson, after that I will step up attendance every week for two additional lessons until regular attendance is achieved.
- *Plan B*: In case I'm not able to regularly attend school after the 4 weeks, I will attend the inpatient unit.
- *Plan C*[2]*:* In cases of refusal to consent to inpatient treatment, a judge may be asked to make a decision about the need for involuntary inpatient treatment.

### Treatment Progress

After Week 4 of MT, M. was able to attend school for the first time in 4 months. The treatment then aimed to promote further school attendance using standard CBT interventions. These included interventions for M.'s social anxiety (e.g., identification of dysfunctional thoughts; social skills training) and for her relationship with her mother (parental training such as contingency management; support of autonomy development).

M.´s school attendance stabilized over the following 8 weeks. On one occasion following a long weekend she missed the first two lessons, but she attended the rest of the day after telephone coaching by her therapist. The number of therapy sessions was reduced from once or twice per week to twice per month for the following 2 months. With the therapist´s help M. developed a relapse prevention agreement:

- I will continue to fight against my anxieties and continue school attendance.
- I will contact my therapist in case of signs such as increasing stomachaches, headaches before school, reduced contact with my friends, and missed classes.
- I agree to have my teacher support me, by allowing her to immediately contact the therapist in case of school nonattendance.

At treatment termination, M. had received 22 CBT module sessions (including 2 sessions for diagnostic purposes and 8 group sessions), 12 FC sessions, and 3 SC sessions. At first M. had difficulty participating in the PE module but ultimately she attended 10 PE sessions.

## Discussion

The MT is based on a multilevel model of problematic school absenteeism. The multidisciplinary team focuses

[2] The probability of a judge ordering involuntary treatment for youth over 13 years is low; it depends on whether prolonged absenteeism is associated with a form of child maltreatment.

on both the problematic school absenteeism and the respective mental disorder(s). After preparation of an extensive case conceptualization, which incorporates motivational aspects, all patients receive interventions within the CBT module. When indicated, the patient also receives interventions from the FC and SC modules. Participation in sessions from the PE module becomes optional after three compulsory sessions. The case vignette of M. illustrates case conceptualization, the coordinated implementation of the modules, and the graduated A-B-C plan.

With regard to development of the MT, the task of addressing a broad spectrum of disorders associated with problematic school absenteeism was solved by adopting elements from several disorder-specific treatment manuals. The MT thus resembles the Modular Approach to Therapy for Children with Anxiety, Depression, or Conduct Problems (MATCH; Chorpita & Weisz, 2009), whereby modules addressing different disorders can be combined according to the patient's needs. A similarly flexible approach was chosen for the MT described in this paper. The modules and interventions are selected and adapted to address variations in problematic school absenteeism and the needs of the patient and family.

The @School Program (Heyne et al., 2008) is a modular intervention that shares similarities with MT. It focuses on school attendance, it incorporates interventions with the young person, family, and school, and modules are selected and dosed based on the needs of the case. However, it was developed specifically for school refusal and not for school attendance problems more broadly. Thus, it does not focus on interventions for conduct disorder in the way that the MT does. Another difference is that the MT employs a multidisciplinary team perspective for treating problematic school absenteeism. Professionals from multiple disciplines work in a team headed by a CBT therapist who coordinates the implementation of all four MT modules. Coordination of the delivery of the various modules in the MT is likely to be a necessary condition for the success of the intervention.

The home visits offered by counselors delivering the interventions of the FC module are a low-threshold form of treatment engagement for the most anxious, recalcitrant, or unmotivated patients. This low-threshold intervention seeks to eliminate barriers to treatment such as travel to an outpatient treatment setting or ambivalence with regard to treatment. This ambivalence may stem from stigma and shame associated with visiting a psychiatric outpatient department, and negative views of mental disorders.

With regard to the PE module, our impression is that patients who choose to participate in all 12 sessions are more likely to return to school. However, this may not hold for all youth with problematic school absenteeism. The majority of patients who fully participated in the PE module and who displayed good outcomes were school-refusing youth with anxious and/or depressive symptoms. Youth displaying school refusal may be more compliant to the PE module and to treatment in general, relative to truant youth diagnosed with an externalizing disorder. Higher compliance is likely to be associated with better outcomes. Another possibility is that youth with depression responded well to the PE module, because of the known positive effects of physical exercise on depressive symptoms and self-efficacy (Mikkelsen, Stojanovska, Polenakovic, Bosevski, & Apostolopoulos, 2017). Indeed, school-refusing youth often experience depressive disorder, as do some truant youth (Heyne, Sauter, & Maynard, 2015). Systematic investigation of the differential benefits of PE interventions for school-refusing youth and truanting youth seems warranted.

To develop a better understanding of the treatment needs of patients with different types of problematic school absenteeism, we conducted post-hoc analyses of data from the study reported by Reissner, Jost, et al. (2015). The data pertained to 56 youth who were classified as displaying school refusal ($n$ = 33; 59%), truancy ($n$ = 9; 16%), and mixed school refusal and truancy ($n$ = 14; 25%). At 1-year follow-up there were 29 cases (52%) available for the assessment of the primary outcome: school attendance. The highest rates of regular school attendance (i.e., 90% attendance or more for the last five school days) were achieved by patients classified as school refusal only (75% of school refusal youth achieved the criterion) and school truancy only (60% of truant youth achieved the criterion). The group with the lowest rate of regular school attendance was the mixed group (50% of youth). Indeed, 38% of youth from the mixed group (3 out of 8 youth) had no school attendance at the 12-month follow-up, compared with 20% of the truant group (1 out of 5 youth) and none of the school refusal group (16 youth).

While the previously published study of Reissner, Jost, et al. (2015) suggested that MT may be beneficial for some youth with school attendance problems, the post-hoc analyses reported in the current study suggest that the MT may be less effective for cases of mixed school refusal and truancy. Related to this, the study of Egger et al. (2003) indicated that the mixed group was more severely disturbed than the groups of youth displaying pure school refusal or pure truancy, with regard to psychosocial functioning and the likelihood of a diagnosis. These findings, together with the post hoc findings of the current study, support the value of differential classification of problematic school absenteeism. Further research might focus on clinically relevant demarcation between subtypes of absenteeism, which may guide treatment-matching. Matching treatment to the type of absenteeism

may increase the number of treated youth achieving regular school attendance.

Finally, our clinical experience suggests that motivational work aimed at engaging patients in treatment may be especially relevant for the truant group and the group displaying mixed school refusal and truancy. The multidisciplinary team felt that the MI approach was useful in motivating these patients to engage in the four modules of the MT, and reducing the likelihood of them dropping out of treatment. The MI approach seemed particularly helpful if there was a long history of school absenteeism and if patients had relapsed and needed to reenter treatment. As is the case in addiction treatment, connection to the health service system can be achieved via low-threshold counselling. The therapist keeps "loose" contact with patients who have low motivation for therapy (e.g., one appointment every 3 months), so that therapeutic help is easily accessible in times of need.

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