

Developmental Trial of a Cognitive Behavior Therapy Program for Parents of Junior High Students Exhibiting School Refusal: Evidence Based on a Small Sample from a Metropolitan Area in Japan

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Objective: School refusal among students may cause parents to lose confidence in their ability to manage children's non-attendance, which can in turn lead to their inability to facilitate the children's return to school. Researchers have considered cognitive behavioral therapy (CBT) as a viable means of boosting the self-efficacy of parents of children with various problems. Nevertheless, there has been little attention to parent's mental health condition in this population. We developed and evaluated a parent support program to promote the mental health of parents of students with chronic absenteeism through CBT. Specifically, by improving stress management and cognitive reframing skills, it was expected to improve parental psychological well-being and their quality of life.

Methods: Using a non-randomized (i.e., single-arm) trial design, we recruited 20 parents from 18 families and divided them into groups of 4-6 members for the CBT program, which comprised 6 weekly sessions over about 3 months between October 2013 and November 2014. Treatment results were evaluated using self-reported questionnaires before and after the program (Time 1 and 2), and in a three-month follow-up period (Time 3). Parents were asked to report their mental health condition such as depression, anxiety and stress (DASS-21), coping style (The Ways of Coping Checklist), and quality of life (WHOQOL-BREF). In addition, parents rated their satisfactory with the program contents and services.

Results: Depression and harmful self-blame significantly decreased, and positive cognitive reframing significantly increased. Furthermore, both the physical and psychological domains of quality of life improved.

Conclusions: The results indicated that the CBT parent support program was effective in alleviating parents' mental health problems and improving their quality of life.

Keywords: Cognitive behavioral therapy; school refusal; parent support program; stress management; Japan

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I. Introduction

School attendance problems pose a serious threat to young people's academic and socio-emotional development¹⁾, and increase the risk of premature school dropout^{2, 3)}. According to available data in Japan, the number of students in primary and junior high schools who exhibited school refusal is estimated at 119,617, which comprises 1.17% of them⁴⁾. Furthermore, latest data have indicated that, for the first time in six years, school refusal has increased, especially in junior high school students, with an increase in the number of school refusal students by about 4,000 in 2014 alone. Further,

this number has continued to increase throughout 2015, with a preliminary estimate of an increase by about 2,000 students⁴⁾.

Anxiety is one of the most commonly cited risk factors for school refusal and absenteeism, but it is neither necessary nor sufficient to explain the problem, as many anxious children attend school and many non-anxious children exhibit absenteeism⁵⁾. Therefore, researchers have stressed that complications arising from multiple factors in individual cases produce the highest risk, such as separation anxiety⁶⁾, simple social phobia⁷⁾, and emotional problems⁸⁾. The Ministry of Education, Culture, Sports, Science, and Technology (MEXT)

explored factors associated with absenteeism, noting that emotional problems such as anxiety (28.1%), lethargy (25.6%), and difficulties in relationships with peers (15.0%) were the strongest contributors⁴⁾. Taken together, previous research has highlighted that school refusal behaviors are related to multiple elements or causes.

Other related factors, such as family functioning, may thus contribute to its occurrence. Researchers point that the families of non-attenders are often dysfunctional⁹⁾. For example, McShane et al.¹⁰⁾ noted that family conflict is a major stressor contributing to the onset of school refusal in adolescence. Additionally, children who refuse to attend school often have difficulty in restarting school because their parents may have negative attitudes towards school attendance¹¹⁾. It should be noted that stress and conflict might also arise in the family because of school refusal¹²⁾. Indeed, prolonged absenteeism may lead parents to lose confidence in their ability to manage a child's non-attendance¹³⁾. Reduction in parenting confidence—defined as parents' perceived efficacy in managing difficult situations in child rearing^{14, 15)}—can in turn make it difficult for the child to return to school¹⁶⁾. Furthermore, it can exacerbate parent-adolescent conflict, which is linked with adolescent depression¹⁷⁾. In sum, school refusal can be debilitating not only for the child but also for his/her parents¹⁸⁾.

Regarding the relationship between factors, a positive association has been found between child and parent anxiety^{19, 20)}. Furthermore, untreated parental anxiety may pose a significant risk to the short-term success of child-focused cognitive behavioral therapy (CBT) for anxiety disorders²¹⁾, even though CBT has been found to be effective for treating anxiety²²⁾ and for improving attendance among children with school refusal²³⁾. It appears that the role of parental psychological well-being in treating school non-attendance problems should be examined.

CBT targeting parents (CBT-P) has been effective for treating the anxiety of students with a school refusal^{24, 25)}. CBT-P has typically targeted three sets of parental variables implicated in the development and maintenance of youth anxiety²⁶⁾. According to Silverman et al.²⁰⁾, these variables are as follows: (1) parental positive/negative behaviors toward the child, (2) skills for reducing conflict in the parent-youth dyadic relationship, and (3) skills to manage parental anxiety. Thus, parents can learn how to manage their negative behavior and/or emotion toward their child and to improve their own mental health, which could improve the relational difficulties that seem to be one of the key factors associated with the school refusal

problem.

A group-format CBT-P program²⁷⁾ was found to be as effective as the individual-format program mentioned above was. However, in another study, a family-based treatment focusing on improving parental adjustment—such as their anxiety and stress—had no apparent effect on the outcomes of either parents or children²⁸⁾. Nevertheless, it is proven that CBT helps develop a variety of stress management skills that significantly reduce parents' stress, which, in turn, is connected to their psychological stability²⁹⁾ and cognitive skills related to exhibiting positive behaviors toward their children³⁰⁾.

In the present study, we evaluated the efficacy of a CBT-P program that we developed based on the CBT model, including that proposed by Silverman et al.²⁰⁾, wherein we targeted specific cognitive factors, such as coping styles, which contribute to the directionality of change in mental health among parents of students with school refusal. However, it is important to note that the present program aimed to improve the psychological well-being and quality of life of parents of children with school refusal. Therefore, the examination of the program's efficacy in terms of students' school attendance was beyond the scope of this study.

Our hypotheses were as follows. The CBT-P for non-attendance (CBT-P/NA) would (1) decrease anxiety, depression, and stress; (2) improve quality of life (QOL); and (3) improve the use of stress coping skills and decrease non-useful/harmful self-blame among participating parents.

II. Methods

1. The CBT-P Program for Non-Attendance (CBT-P/NA)

The CBT-P/NA was developed to reduce anxiety and depression through use of stress management techniques among parents of children with school refusal. The program was a 6-session group intervention based on the multi-dimensional stress management model, according to which, family anxiety is conceptualized according to Clark et al.'s³¹⁾ social phobia model. Specifically, this theory states that students tend to avoid and withdraw from social situations because of self-attention. This is supported by the fact that older students with school refusal are more likely to suffer from social anxiety disorder³²⁾, which may account for the poorer response to treatment for school refusal observed in this group³³⁾. It would be important for parents to assist their children in confronting and coping with anxiety-provoking

Table 1 Session Contents of the Cognitive Behavioral Therapy for Parents/ Non-attendance

Session	Contents	Details
1	Psychoeducation Putting problems in perspective and setting goals	Psychoeducation about child anxiety/depression, CBT treatment components, presentation of case formulations Deciding goals related to the presenting problems of parents themselves
2	Cognitive reframing 1	Identifying automatic thoughts (relating to child-parent relationship) Understanding helpful/unhelpful self-talk
3	Cognitive reframing 2	Challenging automatic thoughts (relating to child-parent relationship) Reframing unhelpful cognitions Developing and using helpful cognitions (using flash cards)
4	Stress management	Psychoeducation about stress (especially child stress) Managing parental distress via cognitive and behavioral interventions Improving stress-coping skills
5	Assertion training	Psychoeducation on assertion (considered in terms of parent role) Fostering the development and use of skills for effective communication between parents and adolescents Listening attentively to own children
6	Problem solving Review progress	Training and application of problem-solving skills by RIBEYE method Discussing goals set in first session

RIBEYE stands for Relax, Identify the problem, Brainstorm possible solutions, Evaluate their strengths and weaknesses, say Yes to one (or two), and Encourage yourself for success (Curry et al.,⁵¹).

situations (e.g., social interaction), but to do so, they must themselves understand the nature of anxiety and be able to manage their own distress. The uniqueness of the CBT-P/NA lies in its focus on the processes that underlies the cognitive-behavior relationship of caregivers who play a significant role in support children with school refusal. The characteristic feature of the program is that it does not directly target students with the problem. Instead, it targets parents' stress management and coping skills that can produce potential effects on children's school refusal problems. As such, we ensured that the CBT-P/NA program comprised psychoeducation and skill training based on CBT protocols such as Silverman et al.'s model²⁰, including training on relaxation and self-control skills (Table 1).

Each session comprised two parts, learning and activity. The learning part included psychoeducation on various topics. For example, in the 5th session, the psychoeducation dealt with the topic, "What is assertion?"-namely, how to develop an assertive attitude

and the importance of attentively listening to children. The activity part, on the other hand, centered on behavioral training methods such as discussion or role-play scenarios. The activities used specific situations that parents of students with school refusal might encounter in their daily life. As a part of the activity in the aforementioned 5th session, the participants engaged in role-playing a scenario involving teachers and grandparents, wherein the parents needed to assert the rights and interests of their children.

Furthermore, a different relaxation method was taught in each of the six sessions. Specifically, these methods were as follows: breathing techniques, muscle relaxation techniques, counted breathing techniques, mindful eating with raisins, and visual imagery meditation involving a leaf floating on a stream or picturing a happy place. The relaxation methods were practiced at the end of each session. Participants were also asked to perform the exercise every day, as homework, to ensure that each participant identified which relaxation method worked

best for him/her, which in turn could help build a sense of autonomy and self-efficacy.

Stallard³⁴⁾ emphasized that parents should serve as both, a co-therapist and co-client to their children. Thus, the overall goals of the program were to teach participants how to use stress management skills and cognitive reframing to manage their anxiety. Furthermore, parents were expected to become “mini” therapists for their children and to help with their children’s anxiety by engaging in more positive activities and attempting to reduce the children’s aversion tendencies. The program also taught parents skills related to managing inter-family conflicts, problem solving, and communication.

2. Participants

We originally aimed to conduct a comparison study involving 30-40 parents in intervention and control groups in order to precisely identify the effects of the CBT-P/NA program. However, we had considerable problems in recruiting an adequate number of participants. Consequently, the study was carried out utilizing a single-arm design. We initially recruited 22 parents of junior high school students with school refusal; students were aged 12-15 years. We sought parents of students from a range of adolescent ages to sufficiently cover the spectrum of adolescent development. All participants and students lived in a suburb of Tokyo. According to a preliminary assessment before formal recruitment, we found that children had been chronically absent from school for more than one year, and more than half had not gone to school continuously since elementary school. Two parents declined to participate in the program; one because of her mental condition and the other because of a scheduling conflict. Therefore, 20 parents-comprising 2 couples and 18 mothers were sent the pre-intervention questionnaires by mail, and all of them returned the questionnaires before the first program session. All 20 parents participated in the post-intervention assessment, and 18 participated in the 3-month follow up assessment. The children’s demographic information has been shown in **Table 2**, while the parents’ information has been shown in **Table 3**.

3. Procedure

The study procedures were approved by an appropriate ethics committee. All the intervention procedures were developed by the authors. To recruit participants, we ran a recruitment campaign wherein we explained the

Table 2 Demographic Characteristics of 18 Children from 18 Families

Variable	n (%)
Sex	
Boy	12 (66.7)
Girl	6 (33.3)
Age	
Mean	13.4
Range	(12-15)
Birth order	
First	6 (33.3)
Second	4 (22.2)
Third	3 (16.7)
Only	5 (19)
Health problems	
Mental	6 (33.3)
Physical	4 (22.2)
Mental and physical	4 (22.2)
None	4 (22.2)

study and asked interested individuals to contact the project coordinator by email or phone. Most participants responded to information pamphlets that the project coordinator had submitted to the city, town, and municipal boards of educations of the junior high and special education schools in the study area or to support groups for parents of chronically absent students. Parents provided their informed consent by signing a form.

The six 120-minute sessions were conducted across three months by the first author, who is a school psychologist as well as a registered clinical CBT psychologist. All the measures listed in the following section were completed at the pre- and post-intervention periods and at the 3-month follow-up. We divided participants into groups of 4-6 members for the CBT-P/NA, which was held over several 3-month periods between October 2013 and November 2014.

For each session, a seating chart was written on the blackboard before the participants entered the meeting room at the research center. This was done to stimulate conversation and prevent participants from choosing the same discussion partner repeatedly. After the first session, each subsequent session started with a review of the previous one, as it was necessary for participants to fully understand the contents of the previous session to efficiently progress to the next session. Homework tasks were assigned in each session. The program supervisor emphasized on the importance of using what

Table 3 Demographic Characteristics of Participants

Variable		<i>n</i>	%		
Relation	Mother	18	90.0		
	Father	2	10.0		
Age	40–44	6	39.1		
	45–49	11	55.0		
	50–54	2	10.0		
	≥55	1	5.0		
Family make-up	Married	17	85.0		
	Single	1	5.0		
	Separated	1	5.0		
	Divorced	1	5.0		
	Died	1	5.0		
		Mother		Father	
		<i>n</i>	%	<i>n</i>	%
Education	High school	2	11.1	1	5.5
	College	11	61.1	0	0.0
	University	5	27.8	16	88.9
	Unknown	0	0.0	1	5.5
Employment status	Part-time	4	22.2	0	0.0
	Full-time	2	11.1	13	72.2
	Unemployment	12	66.1	2	11.1
	Unknown	0	0.0	2	11.1
Health problems	Mental	3	16.7	3	16.7
	Physical	3	16.7	3	16.7
	Mental and physical	0	0.0	0	0.0
	None	12	66.7	9	50.0
	Unknown	0	0.0	2	11.1

participants had learned in the program in their daily life. If a participant was absent from a session, private catch-up sessions were provided to that participant; only two were absent from the main program. Ultimately, all 20 participants completed the program. To ensure the fidelity of the intervention, we implemented the following measures: (1) The contents and time schedule of each session was fixed in advance, in an intervention manual, (2) all sessions were carried out by the first author, ensuring that the content for each group was almost the same, and (3) all sessions were recorded on an IC recorder, after permission for the same was secured from all participants.

4. Measures

(1) Parental adjustment

Depression, Anxiety, and Stress Scale 21 (DASS-21). The DASS-21³⁵⁾ is a 21-item self-report version of the original 42-item scale assessing symptoms of depression, anxiety, and stress in adults. We used the official Japanese version of DASS-21. Each item is rated on a 4-point scale from 0 (*did not apply to me*) to 3 (*applied to me very much, or most of the time*). Each subscale of the DASS-21 has high internal consistency (Cronbach's α); depression (7 items), $\alpha = .91$; anxiety (7 items), $\alpha = .84$; and stress (7 items), $\alpha = .90$. Additionally, all scales have exhibited good discriminant and concurrent validity³⁶⁾³⁷⁾. Normal levels range from 0-4, 0-3, and 0-7 on the depression, anxiety, and stress subscales, respectively,

whereas extremely severe symptoms are indicated by scores of ≥ 14 , ≥ 10 , and ≥ 17 , respectively. In the present study, the scale showed good internal consistency (Cronbach's $\alpha = .92$).

The World Health Organization Quality of Life Instrument (WHOQOL-BREF). The 26-item version of the WHOQOL-BREF³⁸⁾ was developed based on over 10 years' worth of research, to assess QOL as a multi-dimensional construct, thereby enabling comparison of the effects of a wide range of diseases and conditions on QOL. We used the Japanese version of this scale. The WHOQOL-BREF comprises the following four subscales: physical domain (7 items), which deals with energy/fatigue, pain/discomfort, and sleep/rest; psychological domain (6 items), which deals with emotions, self-esteem, cognition, and bodily image/appearance; social relationships domain (3 items), which deals with personal relationships, social support, and sexual activity; and environment domain (8 items), which deals with finances, safety/security, freedom, access to educational and health resources, participation in recreation, physical environment, and transport. The remaining two items assess overall QOL. All items are scored on a five-point Likert scale, with higher scores indicating greater QOL. In the present study, the scale showed good internal consistency (Cronbach's $\alpha = .85$).

The Ways of Coping Checklist (WCCL). The WCCL³⁹⁾ is a measure of coping styles derived from Lazarus' transactional model of stress. We used the Japanese version developed by Nakano⁴⁰⁾. The WCCL comprises the following six subscales: problem-focused coping (14 items; e.g., "Made a plan of action and followed it"); positive cognitive coping (10 items; e.g., "Found new faith in life"); seeks social support (6 items; e.g., "Talked to someone to find out about the situation"); blamed self (4 items; e.g., "Criticized or lectured yourself"); wishful thinking (5 items; e.g., "Hoped a miracle would happen" or "Wished I was a stronger person-more optimistic and forceful"); and avoidance (7 items; e.g., "Went on as if nothing had happened"). The problem-focused coping, positive cognitive coping, and seeks social support styles are recommended as effective coping methods for tackling the stressors of daily life. In contrast, blamed self, wishful thinking, and avoidance styles are to be used only when necessary. In this study, the scale showed good internal consistency (Cronbach's $\alpha = .95$).

(2) Parent Satisfaction Questionnaire

This questionnaire was developed to assess parents' satisfaction with the program. Items included rating their

satisfaction with the overall program and the contents (1 = not good-7 = very good), listing what skills were useful for managing their stress and their child's difficult behaviors, and what they needed from the program.

(3) Statistical Analysis

The effects of the intervention for all three outcome variables were analyzed using 1 (Condition: intervention) \times 3 (Time: pre-intervention, post-intervention, and follow-up) repeated-measures ANOVAs. SPSS 20 was used for all analyses. Comments in the Parent Satisfaction Questionnaire were regarded as narrative data, and the skills that the parents evaluated were extracted.

III. Results

Results of the Kolmogorov-Smirnov test indicated normality ($p > .05$), that is, equal variances in the population on the depression and total scores of the DASS, all of the WCCL subscales, and the three subscales of QOL; however, data on four subscales did not meet the normality assumption; two subscales of the DASS (anxiety, $p = .002$; stress, $p = .000$) and the two subscales of QOL (physical, $p = .017$; social, $p = .000$). Overall, the normality of the data was supported. Additionally, the Mauchly's test for sphericity revealed that this assumption was not violated ($p > .05$). The sphericity is an important assumption for a repeated-measures ANOVA, as it refers to the condition in which the variances of the differences between all possible pairs of the within-subject conditions (i.e., two different times) are equal.

Table 4 shows the children's and parents' reported health problems. **Table 5** shows the intervention outcomes at Time 1, 2, and 3. Twenty parents completed the questionnaires to assess program efficacy (i.e., at pre and post-intervention) and 18 parents answered the questionnaires to identify maintenance effects (i.e., the 3-month follow-up). The reason for the attrition ($n = 2$) at the 3-month follow-up was unknown.

1. Health Problems

Children and parents had a variety of health problems. Specifically, six children reported a mental illness and four children reported a physical illness. Of those who had problems, four children had both mental and physical problems. In contrast, among parents, six people each reported mental and physical illness.

Table 4 Children’s and Parent’s Health Problems (Lifetime Experience as Outpatient)

	Children	Parents
Mental illness	Pervasive developmental disorders, adjustment disorder, anxiety disorder, and obsessive-compulsive disorder (n = 6)	Depression, depressive state, anxiety disorder, generalized anxiety disorder, and obsessive-compulsive disorder (n=6)
Physical illness	Asthma, allergic rhinitis, hay fever, sudden deafness, orthostatic dysregulation, sleep apnea syndrome, and general malaise (n = 4)	Hypertension, atopic dermatitis, throbbing pain, gout/hyperuricemia, and sleep apnea syndrome (n=6)

Table 5 CBT-P/NA Program Effects (N = 18)

	M (SD)			F	η_p^2
	T1 (pre)	T2 (post)	T3 (3-month follow up)		
DASS-21					
Depression	6.11 (4.52)	3.83 (3.76)	4.27 (5.11)	5.35 ^e	0.34
Anxiety	2.28 (2.89)	2.78 (3.08)	3.11 (5.25)	0.71	0.09
Stress	6.39 (4.67)	4.89 (4.25)	5.61 (5.09)	2.35	0.35
Total	14.78 (10.4)	11.5 (9.97)	13.00 (14.59)	1.92	0.26
WCCL					
Problem-focused coping	30.33 (5.09)	31.44 (3.61)	29.22 (7.30)	1.41	0.14
Positive cognitive coping	19.39 (4.21)	23.67 (2.25)	20.00 (5.24)	7.56*	0.44
Seeks social support	13.06 (4.73)	14.33 (3.93)	12.50 (5.48)	1.91	0.22
Blamed self	7.83 (2.60)	5.39 (2.52)	5.72 (2.32)	10.40***	0.49
Wishful thinking	8.28 (4.87)	5.94 (2.96)	6.50 (2.90)	3.79	0.33
Avoidance	8.83 (5.17)	7.61 (2.60)	8.83 (3.07)	1.34	0.27
WHOQOL-BREF					
Physical	21.89 (4.82)	23.72 (4.59)	19.28 (5.28)	14.88***	0.51
Psychological	17.33 (3.93)	19.72 (3.03)	18.39 (4.33)	5.94 ^e	0.60
Social	9.39 (1.91)	10.17 (1.82)	9.56 (2.48)	1.90	0.22
Environmental	25.33 (5.57)	27.22 (4.50)	26.39 (6.45)	1.27	0.15
Overall	5.78 (1.56)	6.17 (1.58)	5.83 (1.86)	1.05	0.11

Note. T1 (pre) = pre-intervention assessment; T2 (post) = post-intervention assessment; T3 (3-month follow up) = 3-month follow-up; DASS-21 = Depression, Anxiety, and Stress Scale 21; WHOQOL-BREF = brief version of the World Health Organization Quality of Life Instrument; WCCL = The Ways of Coping Checklist; CBT-P/NA = Cognitive Behavioral Therapy for Parents/Non-attendance. **p* < .05. ***p* < .01. ****p* < .0001.

2. Parental Adjustment

One-way ANOVAs were conducted to measure differences in questionnaire scores between the pre-intervention, post-intervention, and follow-up periods. There was a significant main effect of time on the DASS-21 depression subscale scores, $F(2,34) = 5.35$, $p = .011$, $\eta_p^2 = .24$. Post hoc comparisons indicated that the mean depression score at pre-intervention ($M = 6.11$, $SD = 1.07$) was significantly higher than that at post-intervention was ($M = 3.80$, $SD = 0.89$). However, the follow-up depression score ($M = 4.27$, $SD = 1.20$) did not differ significantly from either the pre-intervention or the post-intervention score. There were no main effects for the anxiety or stress subscales.

3. Parental Coping Style

We noted significant main effects of time for the WCCL subscales of positive cognitive coping, $F(2,34) = 7.56$, $p = .003$, $\eta_p^2 = .30$, and blamed self, $F(2,34) = 10.4$, $p = .000$, $\eta_p^2 = .38$. For positive cognitive coping, post hoc comparisons revealed a significant ($p < .01$) difference between the pre-intervention ($M = 19.39$, $SD = 0.99$) and post-intervention ($M = 23.67$, $SD = 0.53$) scores, as well as between the post-intervention and follow-up scores ($M = 20.00$, $SD = 1.24$; $p < .05$). For the blamed self subscale, we again found significant differences between the pre-intervention ($M = 7.83$, $SD = 0.61$) and post-intervention ($M = 5.39$, $SD = 0.60$) subscale scores ($p < .01$), as well as between the pre-intervention and follow-up ($M = 5.72$, $SD = 0.55$) subscale scores ($p < .01$). None of the other subscale scores (i.e., problem-focused coping, seeks social support, wishful thinking, and avoidance) significantly differed by time.

4. Parental QOL

There was a significant main effect of time on the WHOQOL-BREF subscale scores of physical domain, $F(2,34) = 5.94$, $p = .010$, $\eta_p^2 = .26$, and psychological domain, $F(2,34) = 14.89$, $p = .000$, $\eta_p^2 = .47$. No main effects were found for the other subscales of the WHOQOL-BREF. For the physical domain subscale, the pre-intervention ($M = 21.89$, $SD = 1.14$) score significantly differed from the post-intervention score ($M = 23.72$, $SD = 1.08$; $p < .05$), and both the pre- and post-intervention scores significantly differed from the follow-up score ($M = 19.28$, $SD = 1.24$; $ps < .01$). For the psychological domain subscale, there was a significant

difference between the pre-intervention ($M = 17.33$, $SD = 0.93$) and post-intervention scores ($M = 19.72$, $SD = 0.71$; $p < .01$), and between the post-intervention and follow-up scores ($M = 18.39$, $SD = 1.02$; $p < .05$).

5. Parent Satisfaction with the Program

Parents rated their satisfaction with the program ($M=5.27$, $SD=0.96$) and the contents ($M = 5.83$, $SD = 0.92$). They appreciated the skills learned in the program, especially those related to reframing cognitions, assertion training, case formulation of their anxiety and unhelpful thoughts, stress coping, psychoeducation about cognition and anxiety, and breathing techniques. Parents reported that the program should include longer training on how to speak to the child in order to enhance his/her self-efficacy and change negative self-talk, as well as how to manage the child's anxiety, strong sensitivity, and/or disturbed behaviors. The program did not directly involve children; however, parents wrote that they learned to listen attentively to their child and to be aware of their attitude toward the child. In addition, they liked other features of the program, such as peer support, sharing skills to manage anxious children, and talking with other parents who had the same concerns.

IV. Discussion

The main objective of the present study was to devise a group-based CBT program for improving the mental health of parents of chronically absent junior high school students. We tested three hypotheses in this study. First, we hypothesized that the CBT-P/NA would decrease the anxiety, depression, and stress of the participating parents. This hypothesis was only partially supported; depression (according to the DASS-21) decreased after the intervention, but increased again three months later. Additionally, anxiety and stress showed no intervention effects. It is argued that targeting the mental health of parents will decrease overall family stress and improve parent-children relationships⁴¹). Although we had initially expected the intervention effects to sustain till the follow-up, this was not found in the present study. This suggests that the program should be elaborated in order to extend the duration of its effects.

Although anxiety and stress did not decrease as a result of the intervention, they were in the normal range at pre-test, which may account for this non-significant decrease. Another possible reason was that the children's chronic absenteeism continued throughout the intervention

and after it. A percentage of youths with school refusal behavior exhibit attendance problems that last for longer than two years¹⁶⁾⁴²⁾, which suggests that it is difficult to change school refusal behaviors. The possible mechanism of the CBT-P/NA's effect on depression could have been the peer counseling involved; all participants shared similar experiences and perspectives, through which they related to each other during each session. Peer support interventions have been shown to reduce depression symptoms to a greater extent than usual care has⁴³⁾. It could be concluded that the present program offered an opportunity to connect parents through their common problems.

Second, we hypothesized that the CBT-P/NA would improve the QOL of the participating parents. Again, the hypothesis was partially supported. The physical and psychological domains of the WHOQOL-BREF showed both intervention and maintenance effects. These effects may be a result of the CBT base of the program, as previous studies have shown that CBT for anxiety disorders is moderately effective for improving QOL, especially in the physical and psychological domains⁴⁴⁾. Given that there is little research on the effect of CBT on the QOL of anxious parents⁴⁵⁾, our findings appear to add to the literature on the treatment of anxiety to improve QOL.

Finally, we hypothesized that the CBT-P/NA would increase useful stress coping skills and decrease non-useful/harmful self-blame. This hypothesis was mainly supported. A comparison of pre- and post-intervention WCCL scores showed that participants' use of self-blame as a stress coping mechanism significantly decreased. Additionally, their use of positive cognitive coping significantly increased as a result of the intervention. In the past, parents with higher blamed self subscale scores tended to, on average, have higher scores on depression and perceived burden⁴⁶⁾. Furthermore, blamed self scores are correlated with a lack of social support, and societal and personal stigma⁴⁷⁾.

In each session and homework assignment, participants were instructed to practice the reframing of unhelpful cognitions and development of helpful cognitions, and to use these helpful cognitions repeatedly. This improvement in cognitive restructuring skills may have led to the observed decrease in depression and the use of self-blame as a coping method. This finding is supported by Beck⁴⁸⁾, who claimed that the stereotypical patterns of pessimistic and self-critical thinking, and distorted information processing were essential characteristics of depression.

This study has some limitations. First, our study was mainly practical and did not use a control group; as such, our results may not reflect the reality. Furthermore, the sample size was quite small, indicating low statistical power and generalizability. Second, although participants' stress coping skills, depression, and QOL showed some improvements, post-intervention improvements did not generally remain significant at the 3-month follow-up. This suggests that the number of sessions may not have been sufficient for the participants to learn the necessary coping skills. As such, the program should be revised with an aim to improve its effects. In summary, it would be best to include a control group in future studies and to revise the research procedures and program contents to ensure the maintenance of parental mental health improvements. In addition, the program comprised six sessions that were implemented over eight weeks. It is realistic to expect some absences due to parents' duties or sickness. We therefore conducted catch-up sessions, which were shorter versions of the actual session (about one hour), to help parents understand the session content that they had missed. However, we did not assess the impact of the catch-up sessions on the program effects.

Despite these limitations, our study suggests that the CBT-P/NA is an effective intervention for reducing parental depression, improving QOL, and helping parents acquire effective coping skills, which are all important for reducing the distress of children with school refusal and for helping them resume normal development⁴⁹⁾. Parental involvement may facilitate continuing improvement in students' school refusal problems even after completion of the program⁵⁰⁾. The current study contributes to an evidence base suggesting that school non-attendance problems affect parent's mental health and QOL, and that CBT can help parents of adolescents' tackle school refusal.

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