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The Relationship of Ethnicity and Familial Factors in the Expression of School Refusal Behavior in Clinical and Community Samples

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THE RELATIONSHIP OF ETHNICITY AND FAMILIAL FACTORS IN THE
EXPRESSION OF SCHOOL REFUSAL BEHAVIOR IN CLINICAL AND
COMMUNITY SAMPLES

by

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A dissertation submitted in partial fulfillment
Of the requirements for the

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ABSTRACT

The Relationship of Ethnicity and Familial Factors in the Expression of School Refusal Behavior in Clinical and Community Samples

by

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Failure to attend school can have a devastating impact on a child's social, emotional, academic, and later career development. Psychologists, educators, and researchers from other disciplines have produced large bodies of literature regarding problematic absenteeism. This has led to varying terminology, divergent approaches, assessment, and treatment of nonattendance. Additional research on contextual, proximal, and distal variables, such as culture and family, has been encouraged. The present study involved contextual variables related to school refusal behavior and contained a more representative sample of youth with attendance difficulties than previous studies. Contextual variables included youth and parent ethnic identity, family environment, school climate, and perceptions of daily discrimination. The present study also examined differences between referral sources (community and clinic) on ethnic identity, psychopathology, and functions of school refusal behavior. Results are discussed in respect to systemic levels (i.e., youth, parent, family, peers, school, and community) and implications for assessment, treatment, and/or prevention practices.

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I would like to thank my husband, Andrew, for his support and encouragement throughout my academic career. He has conquered this journey standing beside me the entire way with patience and optimism. I am truly grateful for the nurturing and encouraging environment my family has provided that has allowed me to reach all my academic endeavors and more.

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CHAPTER 1

INTRODUCTION

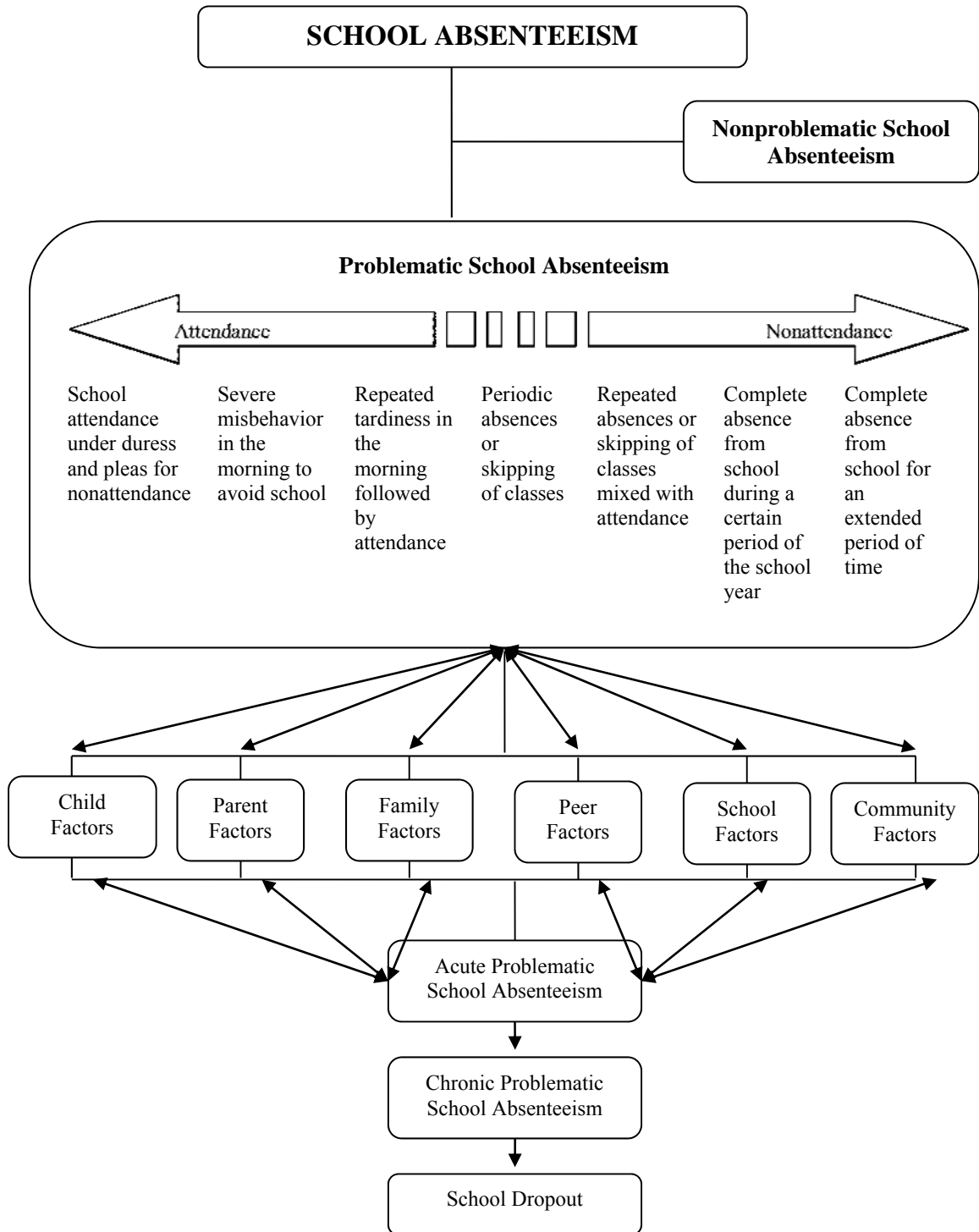
School Absenteeism

Failure to attend school can have a devastating impact on a child's social, emotional, academic, and later career development. Children develop academic knowledge and social skills by interacting with teachers, peers, and others at school. Failure to attend school takes many forms and affects not only the student but family, school, and community systems. This complexity has led to different terminology associated with school nonattendance (Elliott, 1999; Pellegrini, 2007; Thambirajah, Grandison, & De-Hayes, 2008). A better understanding of school nonattendance involves examining all terminology associated with the problem. The following sections illustrate prevalent terms in the literature regarding nonattendance and the historical transformation of conceptualizing absenteeism.

School absenteeism refers to absence from school for any legal or illegal reason (Kearney, 2001, 2008b). School absenteeism can be divided into excused/legal or nonproblematic absenteeism and unexcused/illegal or problematic absenteeism (see Figure 1). *Nonproblematic school absenteeism* occurs when parents and school officials determine an absence to be legitimate and not detrimental to a child (Kearney, 2008a, 2008b). Common reasons for excused absences include illness, religious holidays, family funeral, unsafe weather conditions, and exemption due to college attendance or work circumstances. *Problematic absenteeism* is broad and includes partial and complete days missed from school without legitimate cause.

An historical examination of problematic absenteeism illuminates the multiple terminologies associated with this problem and is presented next.

Figure 1. Interdisciplinary Model of Problematic Absenteeism.



Note. From Kearney (2008). An interdisciplinary model of school absenteeism in youth to inform professional practice and public policy. *Educational Psychology Review*, 20, 257-282.

Discussions of school absenteeism date to writings by Shakespeare and Mark Twain. Shakespeare wrote about whining school boys and an “unwillingness to school.” Mark Twain wrote that Tom Sawyer found the beginning of the school week daunting and that he skipped school. These early stories mimic the current struggles that parents, school officials, and youth describe regarding school attendance. An emphasis on quality education and producing competent workers became a major focus for the educational system after child labor laws were enacted (Kearney, 2001). During the late 19th and early 20th centuries, researchers in education and clinical child psychology came together to assist school officials with the problem of school absenteeism. Educational and psychological explanations for nonattendance resulted in an intertwined terminology.

Many researchers and school districts rely only on complete days missed from school, which may lead to a less accurate understanding of nonattendance. Kearney (2008b) defined specific criteria to encompass all behaviors related to problematic absenteeism. These criteria include missing at least 25% of school time and severe difficulty attending class for at least 2 weeks and/or accumulating 15% or more absences in a 15-week academic period. Missing 25% or more of the school day defines an absence. Problematic absenteeism may also deteriorate over time from acute to chronic absences that can eventually lead to school dropout.

School dropout refers to permanent withdrawal from school before a youth graduates from high school. School dropout could result from an active decision to no longer attend school or from factors out of a youth’s control such as abuse or familial situations such as homelessness. The National Center for Education Statistics (2006) reported that 3.8% of students aged 15-24 years leave school annually. The overall

pattern in the past 30 years was that males left school prematurely more often than females. African Americans (7.3%) and Hispanics (5.0%) have the highest dropout rates compared to Whites (2.8%) and Asian Americans (1.6%). Families with low incomes (8.9%) are associated with higher dropout rates. Students in families with low incomes were 6 times more likely to drop out than their high-income counterparts (National Center for Education Statistics, 2006). Higher dropout rates are more evident in the South (4.4%) compared to other regions of the United States (Northeast-3.8%; Midwest-3.1%; West-3.6%). These statistics suggest the need to better understand demographic and cultural variables with respect to school attendance.

Absenteeism and school dropout are also associated with school withdrawal. *School withdrawal* refers to a caregiver who actively encourages nonattendance or inhibits a youth from attending school. Parents may withdraw a child from school for many reasons. A child may serve as caregiver for younger siblings or provide financial assistance for the family by working. Parental fears, phobias, or separation anxiety may facilitate school withdrawal. Caregivers may fear that other students will harm a child at school and the caregiver will be unable to protect the child. The caregiver may also fear an estranged spouse harming the child. The child may also serve as a “safety person” when the caregiver has a panic attack, agoraphobia, or other disorder. Keeping the youth at home in these situations allows the parent to feel safe by reducing fear and anxiety (Kearney 2001, 2007a).

On the other hand, some youth feel that the demands placed on them at school are excessive or unreasonable, which may lead to *school resistance*. Resistance can be in the form of absenteeism but can also result in subtle behaviors in the classroom such as note

passing, talking during class, and class disruptions. School resistance specifically involves threats or stressors at school for the youth that result in attendance difficulties. As a result, reframing these threats and stressors become extremely important (Kearney, 2001). These definitions usually involve acknowledgement by parents or school officials regarding nonattendance and related behaviors. Truancy, on the other hand, defines the delinquent and secretive components that can be associated with nonattendance.

Truancy

Truancy is defined as an illegal absence from school without parental knowledge that entails acting out and delinquent behaviors (Kearney, 2001). Students who are truant usually hide their behavior from parents or school authorities (Berg & Nursten, 1996; McShane, Walter, & Rey, 2001; Thambirajah, Grandison, & De-Hayes, 2008). They may leave the house in the morning but never attend school, leave during the school day, or not come home from school. Caregivers may believe children are at school when they are not. Truancy may involve antisocial behavior or conduct problems and less anxiety, worry, and fear than other forms of nonattendance (Elliott, 1999; Kearney, 2001; King, Ollendick, & Tonge, 1995; Sommer, 1985). However, components of anxiety may still be present in the truant population (Berg et al., 1985). This mixed symptomatology makes truancy a complex behavior with multiple etiologies (Berg, Butler, Hullin, Smith, & Tyrer, 1978).

Kline (1897) first reported key defining features of truancy that entailed rebellion, unattractive home life, and lack respect and morality. This early definition evolved but key defining characteristics of truancy continued to include a delinquency component (Dayton, 1928; Williams, 1927). Early researchers attributed truancy to a school's

failure to accommodate individual differences through change in teachers and classes and adaptation of grading policies and curriculum to individual needs (Dayton, 1928; Doll, 1921). Parents of truant students were described as lackadaisical or neglectful (Dayton, 1928). Other researchers, however, noted other components characteristic of the truant student.

Williams (1927) examined cases individually to determine the root cause of truancy. He found truancy to be linked to other forms of criminal behavior. Lack of parental authority and control, conflict at home, poverty, and parental neglect all exacerbated truancy. Physical conditions such as handicaps and medical conditions were associated with this early definition (McElwee, 1931). Truant students claimed that poor home conditions, dislike of the school environment, bad companions, and more attractive activities were key reasons for nonattendance (McElwee, 1931). The definition of truancy began to splinter into components of anxiety and delinquency that led to the exploration of different etiologies and additional terminology. However, current research still focuses heavily on the delinquency component associated with truancy.

Henry and colleagues (2007) examined youths in socially disorganized neighborhoods to better understand characteristics of truancy. Truancy was defined as skipping school without an excuse. Their sample was predominantly Hispanic (46.0%) followed by African American (31.9%), White (10.8%), and mixed or other racial identification (11.3%). Truancy was more closely associated with older youth, poor school performance, feeling unsafe at school, gang activity at school, and association with delinquent peers. Association with delinquent peers predicted truancy less for students who performed well academically. However, peer delinquency was a significant

predictor of truancy for students who performed at an average or below average level. Even though significant gender results were not found, more girls skipped school than boys in their sample. This study was unique in that school performance was a protective factor against truancy despite the presence of unhealthy peer relationships. This is extremely beneficial for socially disorganized and high crime neighborhoods where exposure to delinquent peers is high (Henry & Huizinga, 2007). The demographic composition of this sample also suggests the need to examine the role that ethnic identity may play in these neighborhoods and in relation to school-related variables.

School Refusal

School refusal refers to anxiety-based reasons for nonattendance such as panic, social anxiety, worry, or emotional distress. Specific things at school, such as taking tests, speaking before the class, and attending performance-based classes such as physical education or band can trigger anxiety that results in nonattendance (King, Ollendick, & Tonge, 1995). Nonattendance in this population has also been attributed to separation, generalized, or social anxiety (Bernstein & Victor, 2010; Kearney, 2008b). The history of school refusal has led to transformations in terminology and a greater understanding of nonattendance and further delineation between forms of truancy.

Broadwin (1932) described an anxiety component related to school nonattendance. He was the first to delineate different forms of school nonattendance or truancy (Thambirajah, Grandison, & De-Hayes, 2008). Broadwin described a component of truancy that contained a neurotic or obsessional component. Unlike contemporary definitions of truancy, Broadwin felt this form of truancy was not hidden from parents and school officials and that children described school nonattendance in terms of fear.

Broadwin's work was substantial because personality or anxiety components and not simply oppositional behavior defined truancy.

Partridge (1939) further delineated 5 forms of truancy and examined environmental components such as family that may impact nonattendance. Four types of truancy related to delinquent or rebellious behavior. The fifth type of truancy involved anxiety and neurotic components as well as an overprotective child-parent relationship. This aspect of school nonattendance was termed *psychoneurotic truancy* or *school refusal* (Kearney, 2001; King, Ollendick, & Tonge, 1995; Ollendick & Mayer, 1984). Partridge's work led to research that focused on delinquent forms of school nonattendance as well as anxiety and neuroticism. This led to a greater focus on anxiety and phobias with respect to nonattendance.

School Phobia

Johnson, Falstein, Szurek, and Svendsen (1941) suggested a fear component to nonattendance called *school phobia*. An overdependent mother-child relationship, maternal anxieties, and early unresolved dependence defined this component (King, Ollendick, & Tonge, 1995; Ollendick & Mayer, 1984). School nonattendance was the result of fear-based beliefs that something bad would occur to the mother if the child left home and attended school. A mother's anxieties about her child leaving and sympathy that school was an unpleasant place exacerbated this school phobia. This process was later termed *separation anxiety* (Estes, Haylett, & Johnson, 1956).

Waldfogel, Coolidge, and Hahn (1957) defined school phobia by examining the role the school environment plays in nonattendance. This led to expanding the definition to school-centered factors in addition to home and maternal fear-based factors. Coolidge,

Hahn, and Peck (1957) expanded the definition further by describing two types of school phobia: neurotic and characterological. The neurotic type was similar to previous definitions of school phobia that included clinging, phobic reactions, and acute onset. The characterological type was more chronic and symptomatology was a gradual progression of personality disturbances formed at an early age. Research supported the idea that different types of absenteeism existed.

Kennedy (1965) revised the neurotic profile proposed by Coolidge and colleagues. He delineated two types of school phobia that addressed duration and other measurable variables related to nonattendance. Type I school phobia was acute (e.g., first episode) and linked to lower grades, early week onset, and good parental communication. Type II school phobia was chronic and linked to higher grades, poor communication with parents, and problematic parental behavior such as neuroticism. Kennedy reported that different types of settings (e.g., community and clinic settings) had uneven distributions of Type I and II cases. Community settings had many more Type II cases than clinic settings. This documentation is important because it shows the complexity of school absenteeism and that type of setting may involve different diagnostic expressions.

A child may also attend school for the entire day but under severe duress that can often lead to future nonattendance. Identifying severe duress at school can lead to early intervention for nonattendance. Many times this severe duress comes in the form of fears and dislikes at school. The fears may be realistic, such as of a bully or giving a presentation before the class. The majority of fear-based school refusal tends to be less realistic. Hersov (1960a) found that common fears of youth who refuse school were harm to mother (34.0%), academic failure (28.0%), ridicule or harm from peers (28.0%),

or the teacher (22.0%). Other school-based fears reported in the literature include fears of violence and leaving home (Smith, 1970).

These multiple definitions led researchers to focus on certain areas and treatment settings. The need to examine broader contextual variables was critical in refining this terminology. A focus on delinquency and anxiety dominated the literature and led to an emphasis on truancy and school refusal. The large focus on these two areas limited the types of attendance issues and treatment settings studied and research was further segregated into two divisions of truancy and school refusal.

Truancy vs. School Refusal

Several researchers have tried to distinguish traditional truancy from school refusal. Galloway (1983) examined youth in disadvantaged areas and divided the sample into truants (parents rarely knew whereabouts of child during absences) and other absentees (parents knew the whereabouts of child during absences most of the time). Quality of housing, length at present address, parental separation/divorce, history of separation/divorce or bereavements, birth order, and medical histories did not distinguish the groups. Family income was low for both groups but parents of other absentees (80%) were more likely to receive Social Security or a similar benefit for the past 12 months than parents of the truant group. More of the truant students' mothers (47%) were also working. Parents in the overall sample had poor mental health but the other absentees' mothers (64%) were more likely to have chronic illness (Galloway, 1983).

With respect to parent reports of youth behavior, the other absentee group more often reported anxiety and reluctance to leave home as reasons for nonattendance. Parents of truant students reported more conduct-related misbehaviors (e.g., lying,

stealing) than parents of the other absentee group. The two groups showed significantly different parental and familial attitudes. Parents of the other absentee group were more overprotective and youth were more overdependent than the truant group. A warm, mutually satisfactory relationship was reported by most of the other absentee group (75%) compared to the truant group (50%). Delinquency offenses were associated with the truant group as well. These findings demonstrate the similarities between truancy and school refusal but delinquency remains a defining characteristic of truancy. No racial characteristics of the sample were provided. Disadvantaged areas have been associated with higher ethnic minority groups so it would be beneficial to understand the role culture or ethnicity plays in this relationship (Hull, Kilbourne, Reece, & Husaini, 2008).

Sommer and Nagel (1991) compared 25 truant students with 25 nontruant students on personal, family, and setting variables over 4 years. The state legal statute of 3 or more unauthorized absences defined truancy. The groups were matched on age, grade, gender, and SES. Truant students were more likely to leave or transfer schools than nontruant students. Truant students tended to live in single parent homes and had more siblings in the home. The truant group was associated with lower semester GPA for all four years and was involved in more school violations such as fighting and smoking. Truant students who graduated were similar to their nontruant counterparts.

Egger and colleagues (2003) examined a large sample of youth aged 9-16 years to determine nonattendance rates. Nonattendance rates were categorized based on symptomatology. Students with attendance difficulties related to anxiety were termed anxious school refusers. Students whose nonattendance was not anxiety-based and where school authorities or caregivers did not approve absences were termed truants. Two

percent of students were anxious school refusers and 6.2% were truants out of a randomly selected sample of 4,500 students in the population (Egger, Costello, & Angold, 2003). Both groups reported sleep disturbances. For the anxious school refusers, sleep problems focused on separation, such as not sleeping alone, and depression-like sleep difficulties such as insomnia and fatigue. The truant group was associated with depression-like sleep problems only. The anxious school refusal group reported more fears about school, had difficulty making friends, and had increased rates of bullying not seen in the truant group. Both groups had conflictual peer relationships. The anxious school refuser group also reported more somatic complaints such as headaches and stomachaches.

Several psychosocial vulnerabilities predicted nonattendance. Living in a single parent home predicted nonattendance for both groups. Attending a dangerous school and having a caregiver treated for a mental health problem were vulnerabilities for the anxious school refusal group. Lax parental supervision, living in an impoverished home, having at least one adoptive parent, and being born to teenage parents were vulnerabilities for the truant group (Egger et al., 2003). Overall, family and school environment were associated with nonattendance. The expression of the behaviors differed even though both groups reported similar difficulties and behaviors. These findings suggest substantial overlap in symptomatology and environmental variables in this heterogeneous population. A wide variety of youth who refuse school could be sampled as well as an investigation of similarities and differences in family environment and youth psychopathology could be explored by examining clinical and community settings.

Attendance patterns and academic expectations also distinguish school refusal and truancy. Truant students tend to leave home during school hours but youth with school refusal tend to stay home to reduce anxiety. Truant students often do not comply with school expectations to complete homework or schoolwork, but youth with school refusal do wish to meet academic expectations (Thambirajah et al., 2008). Truancy and school refusal share common components of nonattendance but the differences and similarities in these youth are not completely understood.

Future research should examine differences between school refusal and truant populations because these populations are not well defined. Understanding nonattendance within and between groups would allow for more individualized treatment and comprehension of nonattendance. The present study provides a better understanding of within and between group distinctions and the role of assessment settings on absenteeism through examination of clinical and community samples. Most researchers have focused only on youths with truancy or school refusal. A wide range of nonattendance behaviors and diverse population of students from multiple settings would present a more complete picture of nonattendance. Furthermore, examining race only in these studies does not accurately represent the variables influencing nonattendance. Ethnic identity provides a more representative examination of this relationship by exploring degree of identification with an ethnic group.

School Refusal Behavior

A key drawback to historical studies of problematic absenteeism has been a disparate set of terms and subtypes that has led to poor consensus regarding assessment and treatment. The term school refusal behavior was designed to incorporate the main

aspects of truancy, psychoneurotic truancy, school refusal, and school phobia (Kearney, 2001). *School refusal behavior* refers to child-motivated refusal to attend school and/or difficulty remaining in class for the entire day. School refusal behavior is associated with youth aged 5-17 years (Kearney & Albano, 2007). School refusal behavior is associated with complete absence from school, skipping classes, or attending some but not all classes during the school day. School refusal behavior is also associated with misbehavior during morning routines in an attempt to miss school, hesitation about attending school, tardiness, pleas for nonattendance, and attending school under duress. School refusal behavior can be seen on a continuum of heterogeneous nonattendance and related behaviors (see Figure 1).

The most severe form of school refusal behavior is *complete absenteeism*, or missing the entire school day. *Partial absenteeism* refers to attending only certain classes or skipping classes. Partial absenteeism also involves tardiness or arriving late to classes. The behavior is problematic even though youth attend some school in partial absenteeism situations. The U.S. National Center for Education Statistics reported that 8.6% of students skip class in any given month, with 64.7% of these students skipping 1-2 days per month. Gender and ethnicity data indicate that more males than females skip class and that African American and Hispanic youth skip class more often (National Center for Education Statistics, 2005). These statistics indicate the importance of examining diversity variables, specifically ethnicity, with respect to school nonattendance.

Kearney and Silverman (1996) attempted to more adequately clarify school refusal behavior by examining nonattendance from a categorical and dimensional model. They examined the function or maintaining features of school refusal behavior. Youth

who refuse school show many different forms of behavior but a focus on maintaining variables of school refusal behavior may allow researchers to more accurately classify school refusal subtypes. This may lead to more accurate assessment and treatment of the behavior.

School Refusal Behavior Subtypes

Kearney and colleagues (Kearney, 2007a; Kearney & Albano, 2004; Kearney & Silverman, 1990, 1993, 1996, 1999) outlined four main functions of school refusal behavior. Youth may refuse school for one or more of these four functions. These functions are broadly categorized in terms of negative and positive reinforcement. These forms of reinforcement motivate or maintain school refusal behavior via removal of an aversive event (negative reinforcement) or via tangible or intangible rewards (positive reinforcement). These functions have also been associated with degree of school nonattendance (Kearney, 2007b).

Negatively Reinforced School Refusal Behavior

Negative reinforcement occurs when youth refuse school to avoid unpleasant or aversive events surrounding school (Kearney & Silverman, 1996). Avoidance of school reduces negative or unpleasant feelings associated with school and reinforces nonattendance. Within this model, youth can specifically refuse school to avoid stimuli that provoke a sense of general negative affectivity, escape aversive social or evaluative situations, or both (Kearney, 2001).

The global state of anxiety and depression in youth defines negative affectivity (Kearney, 2001; Kendall, Kortlander, Chansky & Brady, 1992; King, Ollendick, & Gullone, 1991; Norvell, Brophy, & Finch, 1985; Watson & Clark, 1984). Some youth

can identify stimuli that evoke negative affectivity such as the bus, fire alarm, teacher, or an animal in the classroom (Kearney, 2001). Many youth cannot identify unpleasant stimuli but rather describe a general feeling of “malaise” or “misery” associated with school (Kearney & Albano, 2004). Younger children often report symptoms of anxiety, sadness, and somatic complaints.

Another function of school refusal behavior is escape from aversive social and evaluative situations. Older youth often identify specific social/evaluative situations that motivate school refusal behavior more so than younger children. Examples of social/evaluative situations include public speaking, interactions with others, writing on the board, and taking tests. Classes such as physical education, choir, and driving education have large evaluative components and youth who refuse school may avoid them. Elevated levels of general and social anxiety, stress, depressive symptoms, and somatic complaints are associated with this group (Kearney, 2001).

Positively Reinforced School Refusal Behavior

Positive reinforcement occurs when youth refuse school to gain tangible or intangible rewards outside of school. This may be in the form of attention or tangible reinforcement outside of school such as playing videogames or visiting with friends. Refusing school for attention or intangible rewards is often associated with younger children. Youths may misbehave during the morning school routine to gain attention and stay home from school. Tantrums, screaming, clinging, locking oneself in a room or car, reassurance-seeking, guilt-inducing behavior, exaggerated complaints of physical symptoms, noncompliance, and running away (usually temporarily) are some behaviors these youths engage in to stay home from school (Kearney, 2001). Separation anxiety

may also be associated with this group but is part of overall manipulative, controlling, attention-seeking behavior (Kearney, 2003).

Youths can also pursue tangible reinforcers that are more powerful than those at school. Older youth may seek tangible rewards such as watching television, playing videogames or sports, accessing the Internet, sleeping late, visiting with friends, talking on the telephone, eating off school campus, engaging in drug use, shopping, or working (Kearney, 1995, 2001). This group is different than other functional groups in that less anxiety is present. This group may exhibit symptoms of negative affectivity after being out of school for an extended period. These youth have lower levels of general and social anxiety, depression, fear, and distress than other functional groups (Tillotson & Kearney, 1998). Conduct disorders are often associated with this group (Hersov, 1985; Kearney & Albano, 2004).

Psychological interventions for school refusal behavior focus on key symptoms and proximal variables (Kearney, 2008a). One proximal variable not adequately addressed in interventions is ethnic and cultural variables. School refusal behavior cannot be accurately treated when the focus is on only a few proximal variables. Reduction of anxiety, increased school attendance, and providing behavioral contingency plans for parents to consequence behaviors are general goals of these interventions. Manualized cognitive-behavior interventions increase attendance by managing anxiety through psychoeducation, relaxation training, and exposure-based interventions (Heyne et al., 2002; Kearney & Silverman, 1999). Anxiolytic and antidepressant medications are used in combination with these techniques (Layne, Bernstein, Egan, & Kushner, 2003).

Psychological approaches have been criticized for their large focus on internalizing symptoms and lack of focus on broader contextual factors (Lyon & Cotler, 2007, 2009).

Researchers should continue to examine distinctions among different types of nonattendance. Differentiating school refusal behavior by function could allow for a better understanding of the heterogeneity in this population. More individualized assessment and treatment could be designed by understanding within group differences in these functional types. The four functions of school refusal behavior provide a template for understanding symptomatology and motivation of school nonattendance. Broad contextual factors should be part of this process as well. Contextual factors as well as the relationship between treatment setting and functions of school refusal behavior could be better addressed by examining different treatment settings. The gap in the psychological literature could be addressed by understanding variables such as ethnic identity in these different settings in relation to school functions. Other disciplines have addressed problematic absenteeism and focused on areas lacking in the psychological literature. These approaches are described next.

Other Approaches to Problematic Absenteeism

The fields of social/criminal justice and education have produced large bodies of literature regarding problematic absenteeism. This has led to varying terminology and divergent approaches, assessment, and treatment to address problematic absenteeism. These disciplines must converge and define an interdisciplinary model of problematic absenteeism to be most effective in combating nonattendance (Kearney, 2008a). A summary of these other approaches is presented next.

Social/Criminal Justice Approaches. Researchers from a social/criminal justice perspective tend to view problematic absenteeism as truancy and delinquency. Their focus has been on legal ramifications of nonattendance and broad contextual factors surrounding nonattendance (Kearney, 2008a). Contextual factors such as homelessness, poverty, teenage pregnancy, at-risk neighborhoods, family disarray, and association with delinquent peers relate to nonattendance.

The U.S. Department of Education reported that transportation was a major barrier to education for homeless youth (U.S. Department of Education, 2008). School supplies, emergency assistance related to school attendance, and assistance with participation in school programs related to absenteeism. Zhang (2003) found that youth from impoverished families missed school more than their peers. Teenage mothers also complete 1.9-2.2 fewer years of education and were less likely to complete high school or postsecondary education (Hofferth, Reid, & Mott, 2001). Community variables such as living in disorganized and unsafe neighborhoods were risk factors for nonattendance (Chapman, 2003; Crowder & South, 2003; Henry, 2007).

Broad interventions have been proposed in the social/criminal justice literature such as early education and community services and legal and court implementations. Resources for at-risk and impoverished families such as education, family, and health services have enhanced academic and parenting skills (Bowen & Richman, 2002; Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007). Reynolds and colleagues (2001) examined the long-term effects of early intervention and educational services on social and academic outcomes. Youth who participated in preschool services had higher rates of graduating high school and lower school dropout rates. Youth enrolled in extended

intervention services (additional 4-6 years) had lower school dropout rates, especially for high poverty neighborhoods. Preschool participants also had less juvenile, multiple, and violent arrests. Youth participating in extended services had less violent and multiple arrests. No significant education benefits or reduction in arrests were found for youth enrolled in these services during their school-age years. All youth (preschool, school age, and extended services) in the academic programs had less time in special education and less grade retention (Reynolds et al., 2001).

Community services and court referrals are often integrated into a school system to address attendance (Fantuzzo, Grim, & Hazan, 2005; McClusky, Bynum, & Patchin, 2004). Such services may reduce transportation difficulties and stigmatization that assists with relapse prevention (Kearney, 2008a, 2008b). Home visits are also implemented to reduce these problems (Richtman, 2007; Shoenfelt & Huddleston, 2006). Community efforts to combat truancy sometimes involve collaboration with local law enforcement agencies. A school district in California partnered with law enforcement to conduct police sweeps for truants in the community. Youths apprehended during these sweeps were then assigned to a special in-school suspension program. Severe cases were referred to the juvenile justice system (White, Fyfe, Campbell, & Goldkamp, 2001).

Contextual factors have shown to influence nonattendance and must be incorporated to solve this problem. The information obtained from the social/criminal justice literature provides insight to environmental variables, such as family and community factors, that are critical for addressing nonattendance. However, this is only one component of nonattendance. The educational field has also addressed school-related variables and this approach is discussed next.

Educational Approaches. Many school districts rely on the legal system to define and address truancy (Kearney, 2008a). Reliance on the legal system may be the result of logistical ease, school funding that often depends on attendance, and adoption of zero tolerance policies for tardiness and unexcused absences (James & Freeze, 2006; Reid, 2003). The use of school-based therapy groups is used in addition to legal options (Kearney, 2008a). The education system tends to blend school refusal behavior and truancy approaches when addressing the heterogeneity of youths with problematic absenteeism.

Researchers from an educational perspective often emphasize school-related variables such as reducing victimization and increasing school climate and parental involvement. Nonattendance is reduced by making the educational environment more enjoyable and attractive to students through school-related variables. Educators have implemented counseling programs for peer mediation, social skills training, anger management, and reduction of violence and victimization (Astor, Meyer, Benbenishty, Marachi, & Rosemond, 2005; Mytton, DiGuseppi, Gough, Taylor, & Logan, 2002). Woody (2001) examined a conflict resolution program with students and school staff. The student session was a 4-hour small group training program to enhance communication and reduce conflict through negotiation. The same material was presented to school staff in a 2-hour training session. They also received information on integrating the information and skills into the everyday school curriculum. Woody (2001) found a decline in aggression and an increase in assertiveness and avoidance of conflict situations. These gains were seen at posttest and the end of the school year (Woody, 2001).

Programs that address school climate involve matching curriculum to individual needs of the student, flexibility in course scheduling, and promoting student involvement in activities (Stone, 2006; Worrell & Hale, 2001). Parent-teacher communication and parent participation, home visits, employing translators, and remediating obstacles to school attendance have been utilized to increase parent involvement (Broussard, 2003). Reduced class size and positive community mentors, incentives, and mental health services are also associated with reduced dropout rates for inner-city youth (Lever et al., 2004).

The fields of psychology, social/criminal justice, and education have focused on many different components to nonattendance and approaches to address the problem. The most effective intervention and prevention strategies would be those that involve collaboration among disciplines. This could be achieved by examining nonattendance from many different settings such as clinics, schools, and legal arenas. The present study examined nonattendance from clinic and community settings to better understand nonattendance across these arenas. This information could allow for a more accurate and complete picture of nonattendance that lends itself to the further development of an interdisciplinary model to address problematic absenteeism. Epidemiology and proximal and distal factors related to nonattendance, such as ethnicity, culture, and family environment, need to be examined further to develop a detailed and comprehensive interdisciplinary model.

Epidemiology

Disparity in terminology regarding problematic absenteeism has resulted in considerable variation in nonattendance prevalence rates. Approximately 7.3% of

American students are absent from school on a given day (National Center for Education Statistics, 2007). Bell, Rosen, and Dynlacht (1994) found prevalence rates of 10-20% in different geographical areas of the United States. Higher problematic absenteeism is associated with youth in inner cities, public schools, and larger schools. Schools with larger percentages of ethnic minority students or students living in poverty experience higher problematic absenteeism rates. High school students tend to have the highest rates of nonattendance compared to elementary and middle school students (Kearney, 2001). The Clark County School District in Nevada reports that in 2009-2010 5.5% of students were absent from school on a particular day (Nevada Department of Education, 2011).

Estimated prevalence rates of school refusal behavior range from 5-28% (Kearney, 2001). Varying degrees of school refusal behavior have been associated with this range. Kearney (2001) estimated that 1.1-4.0% of students were completely absent from school and that 4.4-8.8% were partially absent from school. In addition, 4.4-9.5% of students were tardy or misbehaved in the morning to avoid school and 1.7%-5.4% of students exhibited intense fear and anxiety related to school. Prevalence rates were around 0.4% when researchers used strict criteria that included agreement of school refusal behavior among parent, teacher, and child reports (King, Ollendick, & Tonge, 1995). Lower estimates such as 1% have also been suggested (Burke & Silverman, 1987; Last & Strauss, 1990). Prevalence rates in clinic samples are about 5% (McShane, Walter, & Rey, 2001). The variation in prevalence rates reveals the importance of examining community and clinic settings to better understand the scope of school refusal behavior.

Youth Characteristics

Age. Common age of onset for school refusal behavior is 10-14 years (Chazan, 1962; Hansen, Sanders, Massaro, & Last, 1998; Hersov, 1960a; Last & Strauss, 1990; Smith 1970; Torma & Halsti, 1975). Rates of school refusal behavior tend to increase at early ages (5-7 years) when a child enters school (Hersov, 1985) and during transitions to middle school (10-11 years) (Ollendick & Mayer 1984) and high school (14 years) (Makihara, Nagaya, & Nakajima, 1985; Thambirajah, Grandison, & De-Hayes, 2008).

Age of onset for youth referred to specialized clinics varies. Last and colleagues reported mean ages ranging from 12-14 years for anxiety based school-refusal cases (Hansen, Sanders, Massaro, & Last, 1998; Last, Francis, Hersen, Kazdin, & Strauss, 1987; Last & Strauss, 1990; Last, Strauss, & Francis, 1987). Kearney and colleagues reported mean ages of 11.1 and 11.9 years in their school refusal behavior samples (Kearney, 2000; Kearney & Silverman, 1996). Researchers have found that true age of onset may actually be 1-2 years earlier than time of referral (Hansen et al., 1998; Last & Strauss, 1990).

The type of symptomatology associated with school refusal behavior also varies by age. Adolescents tend to refuse school to avoid social and evaluative situations and/or gain tangible reinforcers, whereas younger children tend to refuse school to avoid negative affectivity and/or to gain attention (Kearney & Albano, 2007). Dube and Orpinas (2009) sampled elementary and middle school youth and found that 60% of their sample refused school for positive reinforcement. Separation anxiety is associated with younger children who refuse school (Bell-Dolan & Brazeal, 1993). Phobic symptoms and social anxiety are related to older children and adolescents (Last et al., 1987; Smith,

1970; Vasey, 1995). Onset in early adolescence has been associated with conduct disorder and delinquent behaviors (Moffitt, 1993). More severe absenteeism is associated with older children and adolescents (Hansen et al., 1998).

Gender. No consistent gender differences exist in the expression of school refusal behavior (Frick, 1964; Granell de Aldaz et al., 1984; Kearney, 1995; Kearney & Bates, 2005). Females tend to exhibit more fear-anxiety symptoms and males exhibit more disruptive and oppositional behaviors (Granell de Aldaz et al., 1984; Morris, Finkelstein, & Fisher, 1976). Researchers report varying results on gender predominance of their samples. Some researchers report more females (Bernstein et al., 1997; Hansen et al., 1998; Last & Strauss, 1990) and others report more males (Bernstein & Borchardt, 1996; Bernstein, Svingen, & Garfinkel, 1990; Kearney & Silverman, 1996). More research is needed to understand the role of gender in school refusal behavior.

Race. Research on racial characteristics of youth who refuse school is modest. African American students (7.3%) aged 15-24 years have the highest annual dropout rate followed by Hispanics (5.0%), multiracial youth (4.9%), Whites (2.8%), and Asians (1.6%) (National Center for Education Statistics, 2005). The status dropout rate, or cumulative percentage of students 16-24 years that have dropped out of school, is highest for Hispanics (22.4%) followed by African Americans (10.4%), multiracial youth (8.2%), Whites (6.0%), and Asians (2.9%) (National Center for Education Statistics, 2005). Dropout rates for the 2009-2010 school year in the Clark County School District were highest for American Indians/Alaskan Natives (8.1%) followed by Hispanics (5.5%) African Americans (5.0%), European Americans (3.8%), and Asian Americans (3.0%). Average daily CCSD attendance rates for absences were as follows: African Americans

(6.8%), Native Americans (6.6%), Hispanics (5.5%), European Americans (5.3%), and Asian Americans (3.8%). Other studies show that absences from school are higher for African American than White students (Levine, Metzendorf, & VanBoskirk, 1986; Rood, 1989).

Youth who enter specialized clinics for school refusal behavior tend to be White rather than African American, Hispanic, or Asian American (Bernstein & Garfinkel, 1986; Bernstein et al., 1997; Hansen et al., 1998; Kearney, 2001). Minorities are often underrepresented in clinic settings (Kearney, 2001). Stigmatization of mental disorders, underutilization of mental health services, and premature termination of services has been attributed to these ethnic differences in referral settings (Rawal, Romansky, Jenuwine, & Lyons, 2004; Snowden, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue & Sue, 2003; Varela & Hensley-Maloney, 2009). Reduced cultural sensitivity as well as failure to embrace cultural biases of ethnic minority groups by mental health staff have been suggested as contributions to underutilization of mental health services for ethnic minority groups (Guthrie, 1997; Sue & Sue, 2003). Other variables such as treatment setting and availability may complicate statistics on racial characteristics of youth who refuse school. Henry and Huizinga (2007) examined truant students in socially disorganized neighborhoods with high crime rates. Their sample was more Hispanic (46%) and African American (31.9%) than European American (10.8%). These race statistics may be a function of clinic versus community samples rather than true differences in nonattendance. A more complete and accurate demographic picture of this population could be obtained by examining clinic and community settings.

These statistics suggest group differences in nonattendance based on ethnic variables. Race statistics, however, do not accurately reflect individual differences between or within groups. A more accurate picture of degree of connection, belongingness, and commitment with ethnic group traditions, culture, values, and beliefs is obtained through examining ethnic identity. Ethnic identity allows for an understanding of how salient beliefs, traditions, and behaviors of an ethnic group are in one's life. It also allows for a more detailed understanding of within group differences in an ethnic group. Information obtained about the interaction between school refusal behavior and ethnic identity could allow researchers to understand ethnic group differences in nonattendance. This information could thus serve as a foundation to examine why differences may exist.

SES. Research on the socioeconomic characteristics of this population is lacking. Berg and colleagues (1993) reported that lower family income was associated with increased school absences. Individuals seeking treatment at specialized clinics were lower to middle class (Bernstein et al., 1986; Bernstein et al., 1997; Hansen et al., 1998). Kearney (2007b) reported that families in his clinic had a mean annual income of \$36,640 (N=222). These distributions may not reflect a well-defined picture of this population because a small proportion of individuals seek treatment at specialized clinics.

Related Symptomatology and Diagnoses

School refusal behavior is often associated with a neurotic or anxiety component and a delinquent component (Kearney, 2001). Anxiety typically consists of internalizing symptoms and delinquency is associated with externalizing symptoms. Researchers have tried to diagnostically categorize these behaviors into internalizing and externalizing

symptoms to better understand school refusal behavior. However, many youth with school refusal behavior show internalizing and externalizing symptomatology. Youth who refuse school as inpatient versus outpatient facilities showed few differences in symptomatology (McShane, Walter, & Rey, 2001; 2004).

Internalizing symptoms. Fear/phobia, anxiety, somatic complaints, depression, and general negative affectivity are internalizing symptoms most often associated with school refusal behavior (Kearney, 2001). Hersov (1960a) found that fears of harm to mother, academic failure, teasing or harm from peers, or the teacher were common school-related fears. Smith (1970) found that children with school refusal commonly reported fears of violence, illness, leaving home, and failure. Failing a test, poor grades, and visiting the principal are also reported as fearful stimuli (Granell de Aldaz et al., 1984). Less than 50 percent of the sample in these studies exhibited fear-based concerns, suggesting this is a limited component of school refusal behavior.

Descriptions of school refusal behavior consistently contain an anxiety component. This may involve anxieties about separation from parents, social situations, or stimuli noted above. Depressive symptoms have also been associated with school refusal behavior (Atkinson, Quarrington, Cyr, 1985; Atkinson, Quarrington, Cyr, & Atkinson, 1989; Smith, 1970; Waldron, Shrier, Stone, & Tobin, 1975). Tearfulness, irritability, sleep disturbances, and feelings of worthlessness are depressive symptoms reported by youth who refuse school (King, Ollendick, & Tonge, 1995). Egger and colleagues (2003) reported that youth with school refusal (31.5%) reported difficulties falling or staying asleep more often than youth with truancy (19.4%). Youth with school refusal also report overlap in depressive and anxiety symptomatology (Bernstein &

Garfinkel, 1986). Depressive and anxiety symptomatology can also present in the form of somatic complaints.

Youth who refuse school typically report somatic complaints (Kearney, 2001; Torma & Halsti, 1975). Headaches, stomachaches, vomiting, fatigue, sweating, diarrhea, and menstruation symptoms are commonly reported (Kearney, 2001; Kearney, 2008a). Egger and colleagues (2003) found that somatic complaints such as headaches and stomachaches were reported more by youths with anxiety-based school refusal (26.5%) than youths with truancy (0.7%). These somatic symptoms may result from an actual medical condition but also from stress or attention-seeking.

Parent, teacher, and child reports of situational and personal factors were examined in 114 Venezuelan youth aged 3-13 years (Granell de Aldaz, Feldman, Vivas, & Gelfand, 1987). The sample was matched on age, school, and gender. Three groups were examined with respect to adaptation problems, phobias, and emotional problems. Youths tried to avoid school by becoming physically resistant (51%), crying at school (56%), and complaining of physical symptoms (56%). Separation anxiety was associated with younger children and fear-related concerns were associated with older children. The common characteristic associated with the onset of school refusal among all age groups was beginning of the school year.

Externalizing symptoms. Externalizing symptoms are also seen in this population (Kearney, 2001). Common externalizing behaviors include verbal and physical aggression, noncompliance, clinging, refusal to move, hiding, running away from home or school, temper tantrums, lying, and reassurance-seeking (Kearney, 1995). Externalizing symptoms such as wandering from home and stealing have been a

distinguishing factor of truancy (Hersov, 1960b). Conduct disorder and oppositional defiant disorder symptoms such as fighting with others and vandalism have been associated with truancy in adolescents (Pritchard, Cotton, & Cox, 1992).

Externalizing symptoms are often expressed in conjunction with internalizing symptoms. A child may tantrum but also display anxious/depressive behaviors such as clinging, panic, and irritability (Kashani, Holcomb, & Orvaschel, 1986). Externalizing behaviors are also used to exaggerate and express extreme discomfort regarding school. Running away from school/home, hiding, or seeking reassurance through continual questions can reduce anxiety about school. Tantrums or self-harm are used to gain attention or delay going to school. A youth may stay home and avoid anxiety-provoking events at school by intimidating parents with verbal and physical aggression. A child may also show externalizing behaviors to escape the classroom or force school officials to contact parents or suspend the child from school (Kearney, 2001).

Psychiatric conditions. Psychiatric conditions have been associated with school refusal behavior (see Table 1). These conditions may precede absenteeism or result from extended absences (Kearney, 2008a). The three studies presented in Table 1 are superior to past research in that they used large sample sizes and psychometrically sound instruments. Many youths with school refusal behavior meet criteria for an anxiety or mood disorder (King, Ollendick, & Tonge, 1995). Separation anxiety, social phobia, simple phobia, panic disorder, posttraumatic stress disorder (PTSD), major depressive disorder, dysthymia, and adjustment disorders are common comorbid diagnoses in youths who refuse school (Bernstein, 1991; Last & Strauss, 1990). Last and Strauss (1990) examined 63 youths who refused school and separated them into two groups: separation-

anxious and phobic. The most common disorders were separation anxiety disorder (38%), social phobia (30%), simple phobia (22%), panic disorder (6%), and PTSD (2%).

Bernstein and colleagues found similar results regarding anxiety and depression (Bernstein, 1991; Bernstein & Garfinkel, 1986; Bernstein, Svingen, & Garfinkel, 1990). Bernstein (1991) separated 96 youth who refused school into four groups of anxiety only (n = 27), depression only (n = 27), anxiety and depression (n = 24), and no anxiety or depression (n = 18). Conduct or oppositional defiant disorder was found in a majority of the no anxiety or no depression group. More severe symptomatology was associated with the combined anxiety and depression group. Bernstein and colleagues (1990) found greater family dysfunction, specifically in parent/child roles, values, and norms, in the anxiety and depression group. These results suggest that different symptomatology is associated with different types of school refusal behavior. Researchers could more accurately examine the range of symptomatology associated with school refusal behavior by examining youth from different settings (e.g., clinical and community).

Several studies indicate a relationship between school refusal behavior and Conduct (CD) or Oppositional Defiant Disorder (ODD). School refusal behavior can be a secondary feature of a primary Conduct or Oppositional Defiant Disorder. A small proportion of school refusal samples meet diagnostic criteria for CD or ODD (Kearney, 2001). Bernstein and Garfinkel (1986) found that 23.1% of their school refusing sample met criteria for CD. Kearney and Albano (2004) found that 8.4% of their sample had a primary ODD diagnosis and 2.8% had a primary CD diagnosis. Bools, Foster, Brown, and Berg (1990) found that pathology varied by school refusing type, with truants more often receiving a diagnosis of CD than anxious youth who refuse school. Berg and

colleagues (1993) also found that about 32% of their sample met criteria for a disruptive disorder. Egger, Costello, and Angold (2003) found that pure truancy was associated with ODD, CD, and depression more so than youth with anxious school refusal.

Personality Differences. Other research suggests that youths who refuse school display different personality characteristics. Okuyama, Okada, Kuribayashi, and Kaneko (1999) found that duration of school refusal behavior was associated with introverted personality traits. This was especially true for students who did not respond to treatment within a two-year period. Lounsbury, Steel, Loveland, and Gibson (2004) examined the predictive validity of personality traits in 7th, 10th, and 12th grade students. The Big 5 personality characteristics served as broad indicators and 4 other traits (aggression, optimism, tough-mindedness, and work drive) served as narrow indicators.

Openness, conscientiousness, and emotional stability were associated with less absenteeism for all three grades. For 10th and 12th graders, agreeableness was associated with less absenteeism. Approximately 6-12% of variance in absences was accounted for by these traits. Conscientiousness is also associated with less absenteeism in the workplace (Judge, Martocchio, & Thoresen, 1997). Lounsbury and colleagues provided a framework for a potentially proactive approach to problematic absenteeism by identifying personality traits. This study, however, was limited in demographic and ethnic variables as well as examination of SES and effects of the family environment on absenteeism.

Temperament characteristics have been linked with school refusal behavior. However, no definitive characteristics are suggested and further research in this area is needed. School attendance difficulties have been associated with behavioral inhibition

and even anxiety symptoms and disorders (Brandibas, Jeunier, Clanet, & Fourasté, 2004; Hirshfeld et al., 1992; King et al., 1998). Maziade and colleagues (1985) found that “temperamentally difficult” children in their sample were more likely to show the same symptomatology at school and at home. At home these children exhibited oppositional behaviors and at school they exhibited more internalizing symptoms such as worry, fearfulness, and tearfulness. Maziade and colleagues (1985) found that parenting skills could buffer these temperament characteristics. Similar research suggests that infants with neurological deficits are predisposed for difficult temperament, poor self-control, and lowered verbal and executive function (Moffitt, 1993). Poor parenting skills and inadequate social and academic skills exacerbate these early deficits. This research suggests that parental characteristics and individual child differences are associated with problematic absenteeism.

Parental Characteristics

Parental Involvement. Parental involvement is a critical component in academic success and school attendance. Parental involvement may involve activities such as reading to a child, checking homework, talking with a child about school matters, interacting with teachers to discuss academic progress, being an active partner in a child’s education by advocating for the school, setting academic challenges for a child, providing a home environment that promotes education, and limiting television viewing (National Education Association, 2008).

Parents need to be actively involved in monitoring a youth’s school attendance. In 57.9% of truancy situations, school officials did not inform parents about unexcused absences (Guare & Cooper, 2003). Sheldon (2007) examined school-wide partnerships

with the family and community in 69 elementary schools (an additional 69 schools were used as control). Family involvement in education increased school attendance (Sheldon, 2007). Falbo, Lein, and Amador (2001) examined parental involvement during the high school transition period (8th to 9th grade). Parental involvement was examined in terms of indirect and direct monitoring. Possible problems that parents could address before significant issues arise were identified by monitoring attendance related behaviors. Parental involvement in school work, associating the teen with desirable peer networks, and direct participation with the school resulted in successful transitions. All forms of parental involvement increased academic success with respect to GPA, credits earned, and attendance (Falbo et al., 2001). Conflict and poor interaction between parent and school officials, low teacher expectations, and excessive absences by the teacher reduce parental involvement in academic and attendance matters (Brand & O'Connor, 2004; Martinez, DeGarmo, & Eddy, 2004; Teasley, 2004). Egger and colleagues (2003) also found that truant students tended to have less adult supervision.

Parental involvement and dropout relate to ethnicity as well. Martinez, DeGarmo, and Eddy (2004) examined 564 Latino and non-Latino youth and their parents. Latino youth reported more incidents of discrimination and institutional barriers such as access to staff resources. Parental involvement with the school and encouragement from parents seem to be protective factors by increasing academic success (Martinez et al., 2004). Little research has examined the role these ethnic considerations (e.g., acculturation, interaction with school and staff) play in academic success and school refusal behavior.

Family involvement in the academic career of a youth is associated with school attendance (Astone & McLanahan, 1991; Duckworth & DeJong, 1989; McNeal, 1999a).

Schools that want to increase attendance rates should collaborate with parents to reduce absences (Epstein & Sheldon, 2002). Interaction with the family through home visits and a contact person at the school reduced rates of chronic absenteeism involving 20 or more missed school days (Epstein et al., 2002). Researchers should examine family-school partnerships to better understand and treat youths with problematic absenteeism. The interaction of familial and school-related variables such as nonattendance could be better understood by examining the role of the family environment.

Parental Psychopathology. Parental psychopathology has also been examined in relation to school refusal behavior. Torma and Halsti (1975) reported that 15.1% of mothers and 21.9% of fathers in their sample had some form of psychosis, alcoholism, or asocial behavior. An overwhelming majority of mothers (80.8%) and almost half of fathers (47.9%) reported severe forms of neurosis or immature personality (Torma & Halsti, 1975). Timberlake (1984) found that many parents of children with school phobia reported medical problems (62.2%), fearfulness or phobia (59.5%), or social inactivity (67.6%) themselves.

Martin, Cabrol, Bouvard, Lepine, and Mouren-Simeoni (1999) divided their sample of youth with anxiety-based school refusal into separation anxiety and phobic disorder groups. Parents of youths in the separation anxiety group had less social phobia but more panic disorder or agoraphobia than parents of youth in the phobic group (Martin et al., 1991). Last and colleagues (1990) found that 33% of youth who refused school in their sample had a maternal family history of school refusal behavior. Most school refusers in the separation-anxious group (75%) had a maternal history of school refusal behavior compared to the phobic group (18%).

Familial Characteristics

Early researchers examined the relationship between family environment and school refusal behavior from a psychodynamic orientation. Families with youths who refused school were characterized as enmeshed with a problematic mother-child relationship and a passive father. Hersov (1960a) tried to empirically identify three types of parent-child relationships in these families. The first parent-child relationship was characterized by an overindulgent mother, a passive father, and a child who was demanding at home but timid in social situations such as school. The second relationship was characterized by a controlling and demanding mother, a passive father, and a child who followed directions at home but was fearful and timid away from home. The third relationship involved a controlling father with high involvement in familial management, an overindulgent mother, and a child who was demanding at home but friendly and outgoing at school.

Berg and McGuire (1974) concluded from their research with school phobia that mothers tended to be overprotective and foster dependency in their children. Waldron and colleagues (1975) found that school phobic families were characterized by separation issues, particularly with mothers. Timberlake (1984) found that parents of children with school phobia exhibited overprotective attitudes. However, Berg, Butler, Fairburn, and McGuire (1981) compared inpatients with school phobia to other adolescent inpatients and found no differences in family dysfunction. One criticism of this finding was that the sample size was small and psychometrically sound instruments were not used. This early research was heterogeneous and primarily focused on the parent-child relationship and enmeshment that led researchers to examine the entire familial relationship.

Contemporary school refusal behavior research has involved a broader context regarding family dynamics and the use of psychometrically sound instruments. Bernstein, Svingen, and Garfinkel (1990) used the Family Assessment Measure (FAM) to assess family functioning in a school phobic population. The FAM allowed researchers to assess families on 7 domains of family functioning: task accomplishment, role performance, communication, affective expression, affective involvement, control, and values/norms. Single-parent families and intact families were compared and single-parent families reported dysfunction in role performance. Role performance focuses on the definition and evolution of family roles. Dysfunction in this area involves disagreement among family members regarding family roles, especially during transitions.

Bernstein and Borchardt (1996) found similar results regarding family role performance and structure. They divided youths with school refusal behavior into single-parent (mother) families ($n = 40$) and dual-parent families ($n = 61$). The mother only group scored higher on role performance and communication. This group may be less likely to adapt to familial role change. They also have difficulty discussing misunderstandings and defining family roles. Single mothers may find it difficult to establish boundaries and parental roles in the family system that make enforcing school attendance difficult (Kearney, 2001). Mothers in this group also reported slightly more psychological symptoms than mothers in intact families. However, these results were not statistically significant and symptomatology remained in the normal range for both groups.

Different types of family dynamics are associated with families of youth who refuse school. Kearney and Silverman (1995) described several subtypes of family functioning: healthy, enmeshed, conflictive, detached, and isolated. Family Environment Scale (FES) results from 64 youths who refuse school were the basis for these findings. Involvement and understanding of family members and engagement in healthy problem-solving strategies characterizes the health family. The family relationship is a central focus and the family dynamic is characterized by high levels of cohesion and expressiveness and low levels of conflict (Kearney et al., 1995). FES cohesion and expressiveness subscales scores of 60 or above have been associated with families that support one another and provide a healthy family environment. Kearney and colleagues (1995) found that 39.1% of their school refusal sample met these criteria. A significant number of families with youth that refuse school exhibit healthy family relationships, but others experience dysfunction in the form of enmeshment, conflict, detachment, and isolation (Kearney, 2001).

Patterns of parental overprotectiveness and overindulgence toward a child characterize the enmeshed family. These families exhibit dependency among family members. Higher levels of dependency characterize families of youth who refuse school compared to families with other psychological disorders (Waldron, Shrier, Stone, & Tobin, 1975). Kearney and colleagues (1995) reported that 32.8% of their sample scored below the norm on the independence subscale of the FES, suggesting enmeshment. Families with young children sometimes exhibit an enmeshed family dynamic. The role of separation anxiety and enmeshment in school refusal behavior is not as pervasive as once thought.

Another subtype is the conflictive family. Hostility, violence, and conflict such as verbal or physical fighting may characterize these families. Psychodynamic perspectives explain the conflictive family type as an expression of the mother-child relationship. The mother may be exhibiting aggression and hostility as part of repressed feelings of resentment toward her offspring (Kearney & Silverman, 1995). A behavioral perspective explains this hostility and conflict as part of the child's persistent attempts to remain at home that create conflict. A family perspective approach maintains that inadequate boundaries result in conflict. Fighting and conflict may maintain school refusal behavior because solutions to the problem are not generated (Kearney & Silverman, 1995). Kearney and Silverman (1995) reported that 23.4% of their sample reported high levels of conflict.

The detached family is characterized by lack of involvement with one another. In these families, parents are not greatly involved with the youth's activities. If a problem does arise, parents may not get involved until the issues are readily apparent and severe. Fathers from these families tend to be passive and withdrawn (Hersov, 1960a, 1960b). The first description of the detached family relationship in a school refusal population described the mother as withdrawn and overwhelmed by the youth's needs (Weiss & Cain, 1964). Youths who refuse school may stay home because of fear that their own needs and stressors at school will repel their mother (Kearney et al., 1995). Waldron, Shrier, Stone, and Tobin (1975) found that families of youth with school phobia (38%) had an imbalance in parental roles. The relationship between mother and child was close but the father was more distant than for children with other types of disorders (9%). These findings suggest that the family environment impacts school refusal behavior.

An isolated family is characterized by lack of contact with others outside the family. A problematic mother-child relationship has been associated with family isolation (Wahler, 1980). Isolated families may be less likely to seek treatment for school refusal behavior (Kearney & Silverman, 1995). Kearney and colleagues (1995) used the FES to examine the intellectual-cultural orientation and active-recreational subscales in families of youth who refuse school. Approximately 28.1% and 31.3% of these families, respectively, reported scores of 40 or below in intellectual-cultural orientation and active-recreational subscales. These results suggest that a proportion of families of youth who refuse school isolate themselves from other systems. However, these percentages could be an underestimate because isolation may inhibit some families from seeking treatment.

Kearney and colleagues (1995) also found that families of youth who refuse school sometimes have more than one familial type. Enmeshed families may have conflict over a lack of family boundaries. Families who exhibit isolation may also be detached. One subtype can occur with the entire family system or different types of relationship dyads can occur between family members. For example, a child may have an enmeshed mother-child relationship but a detached father-child relationship (Kearney et al., 1995).

Different family subtypes are associated with school nonattendance. Lagana (2004) examined 168 adolescents on a continuum of risk for dropout. Participants were in a mainstream program (low risk), an at-risk program (medium risk), or an alternative night program for dropouts (high risk). Adolescents in the low-risk group reported more family cohesion than the medium-risk group. Inpatient and outpatient youth with

difficulties attending school also reported conflict at home and family separation (McShane, Walter, & Rey, 2004). Hansen, Sanders, Massaro, and Last (1998) found greater levels of absenteeism in children of families that were less active and socially involved.

Bernstein, Svingen, and Garfinkel (1990) examined families of children with school phobia via the FAM to measure understanding and interaction among family members. Children with school phobia and no anxiety or depressive disorders (17.4%) were more dysfunctional than children with school phobia and an anxiety or depressive disorder (30.4%). Mothers in the anxiety and depressive disorders group reported poorer family communication.

Birth order, family size, marital status, and marital problems represent other family variables studied in school absenteeism samples. Some researchers have found that the youngest child in a family often exhibits school refusal behavior (Smith, 1970). Berg, Butler, and McGuire (1972) found that 55% of youth with school phobia were the youngest or only child. Torma and Halsti (1975) found that 43.8% of youth with school refusal behavior and truancy were only children or the youngest child in the family. Makihara and colleagues (1985) reported that one-third of youth exhibiting school refusal behavior were only children. Other researchers have found that children exhibiting school refusal behavior tend to be the eldest child (Baker & Wills, 1978; Warnecke, 1964). Granell de Aldaz and colleagues (1987) found that youths with school refusal had more siblings (32%) and mothers who refused school (7%) compared to controls.

School refusal behavior has also been associated with family stress from marital problems. Timberlake (1984) found that 52.7% of parents of children with school refusal

behavior reported marital problems. These parents reported communication problems (79.7%) and multiple family stressors (55.4%). McShane and colleagues (2001) reported that 54% of their sample came from two-parent households but that 43% reported conflict at home prior to onset of school refusal. Torma and Halsti reported that 45.2% of their sample lived in two-parent households. Other research suggests that youth with school refusal behavior tend to be from single-parent families (Berstein & Borchardt, 1996; Berstein, Svingen et al., 1990).

Different family environments seem to lend themselves to different types of attendance difficulties. Most of these studies examined family variables in specialized clinics, so family environments of youth who refuse school who are addressed in community settings are not completely understood. The interaction between family environment and school refusal behavior in multiple settings is critical for developing a comprehensive interdisciplinary model of problematic absenteeism that can be applied to a broad population. Researchers should examine the family environment with respect to school refusal behavior functions in clinical and community samples. Other proximal and distal variables, such as ethnic identity, can thus be examined in relationship with family environment and nonattendance.

School/Community Environment and Peer Interaction

The climate or school environment also influences school attendance. School climate refers to student connectedness to a school via academic, social, and other support (Kearney, 2008b). The school climate embodies positive management of the classroom, participation in extracurricular activities, and adequate disciplinary procedures. Several researchers have suggested that acceptance, value, safety, and

respect also comprise school climate (Brookmeyer, Fanti, & Henrich, 2006; McNeely, Nonnemaker, & Blum, 2002; Shochet, Dadds, Ham, & Montague, 2006).

Brookmeyer and colleagues (2006) examined National Longitudinal Study of Adolescent Health data on 6,397 students from 125 schools. School climate and attendance were significantly correlated (.40). School climate was inversely related to school dropout (-.36), suggesting that school climate may be a protective factor in school attendance. Class (-.23/-.35) and school (-.21/-.37) size were also inversely related to attendance and school climate (Brookmeyer et al., 2006).

Boredom at school has been associated with poor attendance, dropout (Guare & Cooper, 2003), and lack of involvement in after-school programs (Weisman & Gottfredson, 2001). Bridgeland, Dilulio, and Morison (2006) found that 47% of youths who dropped out of school said that uninteresting classes were a major factor in their decision to leave. Engagement and participation in school-related activities related to fewer dropouts (South, Haynie, & Bose, 2007). Janosz, Archambault, Morizot, and Pagani (2008) found that a sudden decrease in school engagement or low engagement in early adolescence was associated with greater likelihood of dropout for Canadian students. Youth who are not engaged at school tend to have less positive peer supports at school (Kingery & Erdley, 2007). Involvement in after-school programs are also associated with lower chronic absenteeism (Epstein et al., 2002).

Schools that are smaller, offer more challenging courses, provide positive student-teacher relationships, and have less grade retention are associated with lower dropout (Jimerson, Egeland, Sroufe, & Carlson, 2000; Lee & Burkham, 2003; Sheldon & Epstein, 2005). Granell de Aldaz and colleagues (1984, 1987) found that beginning the school

year (74%), problems with the teacher (23%), problems with other children (21%), and change of school (18%) were the most prevalent factors associated with school refusal. Lessard and colleagues (2008) interviewed 80 youth who dropped out of school. The researchers used interviews to better understand youths' decisions to remain in school and determine precursors to dropout. Youth remained in school when their efforts and contributions were acknowledged and valued. Reasons for finally deciding to leave school included rejection by peers, disengagement from the school environment, and conflict with teachers (Lessard et al., 2008).

Epstein and Sheldon (2002) found that school involvement with a family ameliorates chronic absenteeism. Chronic absenteeism rates were reduced when parents were informed about attendance policies and expectations, when students were praised for good attendance in newsletters sent home to parents, and when students with many absences were provided community mentors (Sheldon et al., 2005). Schools that provided home visits by school staff saw less chronic absenteeism as well (Epstein et al., 2002).

School violence can also influence attendance rates. Violent incidents in schools rose from 71% in 1999-2000 to 81% in 2003-2004. Twenty-eight percent of students (12-18 years) report being victims of bullying in the past 6 months (National Center for Education Statistics, 2005). Youths who are bullied exhibit higher rates of absenteeism than non-bullied students (Dake, Price, & Telljohann, 2003). Youths who have been bullied are more likely to report that the school environment is unsafe, with 20% of these students avoiding school (Glew, Fan, Katon, Rivara, & Kernie, 2005). Kawabata (2001) found that Japanese junior high school students who reported bullying (Ijime) also

refused school. Bullying and an unsafe school environment can be associated with discrimination as well. Youth discrimination was associated with lower grade point average and nonattendance (Benner & Graham, 2011). This research stresses the significant role environment plays in school attendance across cultures.

The school and community environment play a role in nonattendance. Models addressing problematic absenteeism have integrated many school-related components such as bullying and safety. However, a more comprehensive and detailed model must address all of these school-related factors and broad contextual variables. Researchers have begun to incorporate these components into comprehensive models of problematic absenteeism and their work is discussed next.

Future Directions for Problematic Absenteeism

The history of problematic absenteeism and its examination from several different perspectives has resulted in divergent assessment, treatment, and conceptualization approaches. Problematic absenteeism has thus been inadequately addressed. Adequate conceptualization of problematic absenteeism requires a comprehensive model. An emphasis on common terminology and definitions, comprehensiveness from multiple disciplines, and flexibility to account for heterogeneity in this population is critical (Kearney, 2008a).

Kearney (2008a) suggested an interdisciplinary model to address problematic absenteeism based on four main criteria: consistent universal terminology, ease of use, flexibility, and comprehensiveness. Terminology should be broad to cover all perspectives and be understood by researchers, practitioners, and lay persons. The terminology should address multiple perspectives and provide a clear distinction between

problematic and nonproblematic absenteeism. The model should also be user-friendly for many professionals across disciplines and settings.

Educational approaches have relied heavily on days missed from school to define problematic absenteeism. Days missed from school, however, do not cover attendance difficulties such as morning misbehaviors, tardiness, duress at school, and skipping classes. The definition for problematic absenteeism may thus include youths who display the following: (1) miss at least 25% of the school time for a period of 2 weeks or more, (2) experience attendance difficulties that interfere with youth, parent, or family daily functioning for at least 2 weeks, and/or (3) display absenteeism for at least 15% of days during any 15-week period during the school session. The percentages chosen were based on medians from treatment outcome studies. This definition encompasses all behaviors associated with nonattendance (Kearney, 2008a). An interdisciplinary model should also be flexible to account for rapidly changing attendance patterns, symptomatology, and contextual factors. Attendance patterns can quickly change from tardiness and skipping classes to complete days missed from school that eventually leads to dropout. Factors that influence youths' attendance change as well. Parents may allow nonattendance one day but insist on attendance another day. The youth's nonattendance behavior can change from anxious and avoidant one day to disruptive and aggressive another (Kearney, 2008a). The model must be flexible to account for individual differences across cases of problematic absenteeism.

Lastly, the model should be comprehensive and include many proximal and distal factors that contribute to problematic absenteeism. Kearney (2008a) discussed some of the factors that should be included (see Table 2). Child, parent, family, peer, school, and

community factors should be fully addressed to adequately understand and resolve problematic absenteeism. These factors are linked and influence problematic absenteeism concurrently. A youth's nonattendance, for example, can lead to familial conflict that exacerbates nonattendance. Ethnic discrimination experienced at school or the community may exacerbate nonattendance. Problematic absenteeism can create educational ramifications at a larger systems level such as excessive suspensions, loss of instructional time, and district wide attendance issues that influence state and other funding. These factors interact with the community via gang activity, neighborhood disorganization, and discontent among school staff and community members. A multi-level conceptualization of these factors is essential.

Ultimately, adequate professional practice and school policy interventions would address proximal and distal variables at several levels. A model that addresses individual differences could be designed by examining systemic levels and proximal and distal variables. Kearney (2008a) proposed five levels that address risk and severity of problematic absenteeism. The primary level involves youth variables such as psychopathology that influence nonattendance. The secondary level involves parental response to the youth's absenteeism and interaction with youth variables. Youth psychopathology, for example, interacts with parental psychopathology. Parent variables such as conflict with the school and disengagement interact to hinder the resolution of problematic absenteeism. Family or marital dysfunction can also influence this interaction.

The tertiary level involves youth and parental variables from the primary and secondary levels that interact with peer contextual factors. Peer variables such as deviant

peers or lack of friends exacerbate difficulties at the primary and secondary level.

Opportunities to engage with delinquent peers may interface with parental conflict or disengagement as well as youth psychopathology to exacerbate nonattendance.

The quaternary level involves interaction of youth, parental, and peer variables with broad school-based variables. Poor school climate, high grade retention, and unresponsiveness to individualized curriculum are some school-related variables that interact with lower levels to influence problematic absenteeism. Youth and family problems can also make interaction with school officials difficult, which can limit use of school resources and services.

The quinary level involves community factors that interact with all other levels. Community factors such as access to mental health services, and lack of collaboration between police, court services, and community organizations, interact with variables at other levels to make problematic absenteeism difficult to resolve. Problematic absenteeism cannot be adequately resolved if all variables and levels are not addressed.

One area inadequately addressed in this model is ethnicity and cultural aspects. This may be the result of modest ethnic identity literature in the area of problematic absenteeism. Ethnicity and culture, specifically ethnic identity, are variables that impact each factor at some level. At the primary level, ethnic identity impacts one's sense of identity as well as self-esteem and psychological well-being (Phinney, Romero, Nava, & Huang, 2001). At the secondary level, ethnic identity of parents and other family members may agree or conflict with the youth's beliefs. Varying degrees of ethnic identity can exist within the family as well. At the tertiary level, peers may assist or

hinder this identification process. Ethnic identity can be influenced by different peer ethnic views, deviant peers, and peer discrimination.

At the quaternary level, a youth's ethnic identity search may impact behavior and interactions at school. If a youth does not feel the school environment is supportive of his ethnic beliefs, then anger and resentment may lead to behavior problems. Research also suggests ethnic minority groups are less like to receive school-based services than European American counterparts as well as these services are implemented at an earlier age for Non-Hispanic European American youth (Wood et al., 2005). At the quaternary and quinary levels, support and messages obtained from the school and community environment influence this search for identification and interact with other levels. If a youth is berated with discriminatory messages at school and in the community, then this could exacerbate nonattendance. Cultural variables such as ethnic identity are critical to develop an interdisciplinary and comprehensive model of problematic absenteeism. The next sections discuss ethnic identity in youth and research on the relationship between ethnic identity and academic and other risk variables for nonattendance.

CHAPTER 2

CULTURE AND SCHOOL REFUSAL BEHAVIOR

Ethnic Identity

Definitions of ethnic identity range from components of social identity (Tajfel, 1981), self-identification, feelings of belonging, and commitment to a particular ethnic group (Singh, 1977; Ting-Toomey, 1981; Tzurriel & Klien, 1977) to sharing values and attitudes with a particular ethnic group (White & Burke, 1987). Ethnic identity is often confused with acculturation. Acculturation addresses change as two different cultures come into contact (Berry, Trimble, & Olmedo, 1986). Phinney (1990) described several components that comprise ethnic identity development, including self-identification or labeling oneself as belonging to a particular ethnic group, a sense of belonging to that group, positive evaluation or acceptance with the group, knowledge about the group, and participation in activities and traditions of the group. Ethnic identity was found to be more salient for ethnic minority groups than ethnic majority groups (Negy, Shreve, Jensen, & Uddin, 2003; Phinney & Alipuria, 1990; Smith, 1991; Turner & Brown, 2007).

Researchers point to two components that comprise ethnic identity, group membership and a developmental process (Phinney, Romero, Nava, & Huang, 2001). Group membership has been labeled affirmation and belonging. The basis for this component comes from social identity theory (Tajfel & Turner, 1986) and the subjective sense of belonging to a group defines ethnic identity. This group membership produces feelings and attitudes that influence one's identity. A sense of belonging to a group produces self-esteem and results in psychological well-being and self-concept (Phinney & Alipuria, 1996; Phinney et al., 2001).

A developmental process also occurs when exploring ethnic identity. This process is based on developmental theory for identity formation (Erikson, 1968). Identity formation is a critical component during adolescence and ethnic identity formation is believed to occur concurrently. Adolescents begin to explore their ethnicity and group membership in terms of the larger societal structure (Phinney, 1989). Learning about history and traditions and examining ethnic group discrimination and prejudice by discussing issues with family and friends occurs during this process. A sense of ethnic identity, through understanding membership to the ethnic group, is the goal of this exploration (Phinney et al., 2001). Differences in strength of ethnic identity during this developmental process have been found with ethnic identity strengthening over time for ethnic minority groups and ethnic majority groups displaying more stable ethnic identity (French, Seidman, Allen & Aber, 2006).

Ethnic identity evolves and changes over time, especially during adolescence and young adulthood (Phinney, 1996). Phinney and colleagues found that about one-third of African American and European American 8th graders (Phinney & Tarver, 1988) and half of 10th graders (Phinney, 1989) showed ethnic identity development. Ethnic identity has been found to more salient for ethnic minority groups rather than ethnic majority groups (Phinney & Alipuria, 1990; Smith, 1991). Ethnic identification is a progressive process. Studies of youth in early and middle adolescences found a gradual increase in ethnic belonging for both groups and an increase in exploration for middle adolescents (French, Seidman, Allen & Aber, 2006). Studies of middle to late adolescents found an increase in exploration that leveled out after 10th grade (Pahl & Way, 2006). Adolescents and young adults are thought to explore their beliefs and culture to form a secure sense of

ethnic identity (see Figure 2) (Phinney, 1996; Phinney & Ong, 2007). This progression can include revisiting earlier stages (Parham, 1989). The stage model proposed by Phinney (1996) is a guide to understand ethnic development. This model is influenced by the school, family, and community environment.

Figure 2. Stages of Minority Group Ethnic Identity

Stage	Relationship to Own Group	Relationship to Other Groups
1. Unexamined ethnic identity	Positive, negative, or neutral, depending on socialization (in family, community).	Positive, negative, or neutral depending on socialization. Possible white identification.
2. Moratorium or exploration	High involvement; high salience' typically positive attitudes but possible swings of mood.	Increased awareness or racism; possible anger towards Whites and empathy for other minorities.
3. Achieved ethnic identity	Secure sense of group membership; realistic approach of own group; salience may be high or low.	Can vary from acceptance and positive involvement (integration) to preference for separatism as rational approach to discrimination.

Note. From Phinney, J. S. (1996). Understanding ethnic diversity: The role of ethnic identity. *American Behavioral Scientist*, 40, 143-152.

An environment that includes family, one's neighborhood, the community, and social contexts heavily influences ethnic identity of youths at the first stage. School and neighborhood are important contexts that influence the relationship youths form with particular groups (Phinney, Ferguson, & Tate, 1997). Areas with dense racial and ethnic minorities more often have cohesive community atmospheres with increased social networks (Abrahamson, 1996). This community cohesion can come from a sense of shared ethnic identity with neighbors (Crowder & South, 2003). Positive and negative messages youths hear from their environment and family influence the relationship formed with their ethnicity. In some immigrant ethnic groups, parents' maintenance of

their culture positively influenced adolescent ethnic identity (Phinney, Romero, Nava, & Huang, 2001). Increased family cohesion has also been related to increased ethnic belongingness for Asian-, and Latin-, and European-American youth and increased exploration for Asian-American youth (Kiang, Witkow, Baldelomar, & Fuligni, 2010). The relationship between ethnic identity and school refusal behavior can be better understood by examining ethnic identity in families and youth as well as in different contexts such as school.

When a youth becomes more interested in knowing about her ethnic group and searches for information about that group, she enters the second stage. Encounters with diverse individuals and discrimination often trigger this search stage (Phinney, 1996). The educational system can be an important tool in this process because it provides outlets for exploration (e.g., clubs, diversity speakers). This stresses the importance of examining the relationship between ethnic identity and school refusal behavior. A youth's relationship with her ethnicity is usually positive and can be ethnocentric at this stage. However, she may have negative feelings and anger toward the dominant ethnic group that can lead to psychopathology and behavioral problems at school and home, such as problematic absenteeism.

Youth at the third and last stage have secure identification with their ethnicity. A secure ethnic identity does not necessarily mean that ethnicity is salient for that individual. The anger and ethnocentrism seen in stage two usually dissipates. Youth who can work with other ethnic groups tend to integrate their ethnic identity with other cultures. Youth that see no possibility for change tend to separate themselves from other groups and focus on their ethnic group (Phinney, 1996).

Ethnicity Identity and Academic Variables

Ethnic identity plays a large role in psychological functioning and the identification process is strongly influenced by environmental contexts such as school (Phinney, 1990). No published research has been conducted in the area of school refusal behavior regarding ethnic identity. Academic variables such as school climate, achievement, and extracurricular activities have been related to ethnic identity (Davalos, Chavez, & Guardiola, 1999; Esparza & Sánchez, 2008; Irving & Hudley, 2008; Shin, Daly, & Vera, 2007). These studies lay the groundwork for a better understanding of ethnicity and cultural variables in relation to school refusal behavior. Studies also have examined school refusal behavior in the context of different cultural variables. Japan, in particular, has begun to examine school refusal behavior and the relationship with culture. Examining school-related variables with respect to Japanese culture serves as a framework to address ethnic identity and school refusal behavior.

Lock (1986) discussed interpretation of several school refusal cases in Japanese culture. School refusal behavior was officially recognized as a problem in Japan during the 1960s. The definition of school refusal in Japanese culture involves youths who do not attend school but want to go to school. They are at home and stay in bed when not at school. Youths who refuse school are often taken to a medical doctor to be treated for symptoms such as stomachaches. Unlike Western culture, the conceptualization of illness in Japan is seen less in terms of social and emotional states. This conceptualization has been applied to school refusal behavior. Traditional Western medical models have been intertwined in these Japanese models. Many behavior problems in children, illness in the elderly, and even depression is blamed on the family

(Lock, 1986). The medical system in Japan has recently begun to focus on the impact life transitions can have on overall function. Doctors rarely inquire about behavioral information and parents are reluctant to volunteer information about a youth's school refusal. Depending on the symptomatology, a psychiatric disorder is typically diagnosed rather than considering school refusal behavior (Lock, 1986).

Interpretations for school refusal behavior range from blaming the "selfish-mother," poor diet, and assessment of physical symptoms. The Ministry of Education, the main school body in Japan, published a booklet explaining school refusal behavior. This booklet explains the central causes of school refusal behavior as personality-based. Inability to fit into groups, anxiety, and social and emotional immaturity are causes given for nonattendance. The home environment and parent/child relationship are stressed. Spoiling a child, parental characteristics such as lack of a "father-image," or an overanxious mother are considered causes of school refusal behavior. Lock (1986) proposed the need to address school refusal behavior from many different aspects because the Japanese approach hinders an adequate understanding, treatment, and interpretation of school refusal behavior in that country.

Iwamoto and Yoshida (1997) examined Ministry of Education data in Japan and found that 8.1% of students had difficulty attending school. About 13.0% of those cases were considered truancy and included youths who engaged in activities other than school. Twenty-seven percent were considered passive and included youths who were passive at home (e.g., does not throw tantrums). Youths who did not attend school for emotional or somatic reasons were considered neurotic and comprised 26.3% of the sample, and 18.4% were mixed symptomatology. Nonattendance has become an increasing problem

for the Japanese school system because academic programs are extremely rigorous and high expectations exist for achievement.

Iwamoto and Yoshida (1997) studied 50 cases of school refusal behavior in Japanese middle and high schools. Most were diagnosed with adjustment (18) or anxiety disorder (12) followed by separation anxiety (5) and somatoform disorder (3). Youths with separation anxiety, somatoform, and adjustment disorders were more likely to return to school. Most with anxiety disorder did not return to school. This group was more likely to have comorbid social phobia. The behavior is addressed differently based on cultural interpretations even though similar symptomatology is present. Differences and similarities in various cultures, such as youth and parental characteristics and psychopathology, will guide researchers and therapists to cultural variables of interest in school refusal behavior. Other researchers have examined cultural beliefs with respect to school-related variables that may be instructive for absenteeism.

Esparza and Sánchez (2008) examined attitudinal familism in 143 Latin High School students. Familism is a Latino cultural belief that one should care for and be concerned for the welfare of the family. The social support gained from a sense of family is thought to positively impact academic success. Their sample was predominantly second generation (youth born in the U.S. but at least one parent foreign-born; 51%), followed by first generation (students and parents were foreign born; 32%), third generation (parents and youth born in U.S., grandparents foreign-born; 8%), and fourth generation (youth, parents, and grandparents born in U.S.; 3%); 6% of the sample did not provide sufficient information. Students with a strong sense of familism put more effort into academics such as studying and completing homework and skipped class less. This

research indicates the importance of examining cultural aspects with respect to school attendance. Ethnic identity may reveal protective factors beneficial for combating school refusal behavior.

Irving and Hudley (2008) examined 115 African American adolescent males to determine the role ethnic identity and other cultural factors play in academic achievement. Cultural mistrust, oppositional cultural attitudes, and ethnic identity affirmation and belonging were addressed. Ethnic identity affirmation was measured using 7 items from the Multigroup Ethnic Identity Measure (MEIM). Youths were in 11th and 12th grade at an urban, multiethnic high school. The ethnic breakdown of the school was 46% Asian and Pacific Islander, 27% African American, 15% European American, and 12% Hispanic. Ethnic identity affirmation and belonging did not correlate with cultural mistrust or oppositional cultural attitudes. Ethnic identity was unrelated to academic outcome expectation. Academic outcome expectation measures a youth's expected benefits from, and value on, academic achievement and education. Ethnic identity affirmation was unrelated to SES. This study only examined one component of ethnicity identity formation. More research is needed to determine the relationship between ethnic identity and academic variables.

Costigan and colleagues (2010) examined the role ethnic identity plays in psychological adjustment and academic achievement in 95 youth from Chinese immigrant families residing in Canada. Ethnic identity was measured using the MEIM, grade point average measured achievement, self-esteem was measured by the 10-item Rosenberg Self-Esteem scale and depression was measured by the Center for Epidemiological Studies Depression Scale. Youth that endorsed higher levels of

affirmation and belonging and ethnic identity achievement had higher self-esteem and less depressive symptoms. Youth who endorsed higher levels of ethnic identity affirmation also had higher grade point averages. High levels of ethnic identity was associated with stable self-esteem even when grade point average was low. These results suggest that high levels of ethnic identity may serve as a protective factor against poor academic achievement (Costigan, Korysma, Hua, & Chance, 2010).

Davalos and colleagues (1999) matched 958 youth dropouts (318 European American and 640 Mexican American) on ethnicity, grade, and gender to youth in good academic standing (252 European American and 523 Mexican American) to determine factors interacting with school dropout. The Ethnic Identity Scale measures levels of identification with any culture and allows for multiple identifications. Researchers examined level of identification with Mexican American and European American culture. Mexican American and European American cultures were categorized into three levels: high (top 25% of respondents), medium (middle 50%), and low (bottom 25%). Mexican American ethnic identity at any level was unrelated to dropout rates or involvement in extracurricular activities. High and medium identification with European American ethnicity was related to increased school enrollment and involvement in extracurricular activities compared to youths with low levels of such identification (Davalos, Chavez, & Guardiola, 1999). This research suggests that higher identification with the dominant ethnic group is related to increased school involvement. School involvement has been related to increased school attendance as well (Epstein et al., 2002; South, Haynie, & Bose, 2007). This research stresses the importance of examining the role ethnic identity plays in school involvement and participation that leads to increased school attendance.

Shin and colleagues (2007) examined the relationship between ethnic identity and school engagement in 132 7th and 8th graders from diverse schools. The sample was primarily Latino (54.5%) followed by biracial (18.0%), African American (11.0%), Asian American (8.0%), Native American (0.8%), and not identified (6.8%). Ethnic identity was measured using the 20-item MEIM scale. High levels of ethnic identity related to increased school engagement, even when negative peer influence was present. Attitudes towards teaching, learning, social structure/ climate, peers, and school in general defined school engagement. These results suggest that a strong sense of ethnic identity can lead to engagement at school resulting in positive school climate. Ethnic identity seems to be a protective factor even in the presence of risk factors such as negative peer influence (Shin, Daly, & Vera, 2007).

Ethnic Identity and Psychopathology

No research has been conducted with respect to ethnic identity and psychopathology in youths who refuse school. Psychopathology has been associated with different functions of school refusal behavior as well as overall nonattendance. As a result, general prevalence rates of psychological disorders and the relationship with ethnic identity will serve as a guide to drive research in the area of school refusal behavior.

Roberts and Roberts (2007) examined 4,175 youths aged 11-17 years who were European American (35%), African American (35%), Mexican American (21%), or another ethnic background (9%). European Americans had lower risk for anxiety disorders. European American youth were at greater risk for comorbid disorders and substance abuse than African Americans. African American youth exhibited less risk for

comorbid disorders and substance abuse. Ethnic experience factors of ethnic stress, ethnic identity, salience of ethnicity, and perceived discrimination were protective factors for African American youth only (Roberts et al., 2007).

Marie and colleagues (2008) examined 984 youth from birth to age 25 years. Youth were Māori or indigenous people of New Zealand. These data were part of a 25-year longitudinal study where youth were followed at birth, 4 months, 1 year and each additional year to the age of 16, 18, 21, and 25 years. Questions regarding ethnic identity were obtained at age 21 years. Participation in the culture through cultural performances, participating in cultural rituals, and exposure to Māori television, radio or other media comprised ethnic identity. The sample was divided into individuals with sole Māori identity (45.9%) and individuals who embraced Māori identity with another ethnic group (54.1%). Strong sole Māori identity was associated with less mental disorder. Social disadvantage and adversity was also associated with poorer mental health. Further research is needed to determine how strong ethnic identity influences mental health in this population. Whether mental health led to strong identity or whether strong identity led to mental health remains unclear, however. Future research should examine ethnic identity earlier in the development process to better understand this relationship.

Not only is little research conducted on ethnic identity and expression of symptomatology, the literature is minuscule for youth of mixed ethnicity. Researchers have argued that youths from mixed ethnic backgrounds are more susceptible to psychopathology and psychosocial stress (Brown, 2001; Gibbs, 1987; Milan & Keily, 2000; Sue & Sue, 2003). Abu-Rayya (2006) examined the relationship between ethnic identity and psychological well-being in 127 European-Arab youth aged 13-18 years. The

mothers' ethnicity was European and the fathers' ethnicity was Arab. Higher levels of psychological well-being were associated with a positive ethnic identity that included participation in social and traditional activities of the ethnicity identified. Gender did not moderate this relationship.

Race and Psychopathology

The role that ethnic identity plays in psychopathology is critical to understanding problematic absenteeism. Little research has been conducted on general psychopathology and ethnic identity. Many more studies examine race instead. Race does not measure how salient a person's ethnicity is, if at all. A person may be born a certain race, for example, but identify with a completely different ethnicity. The relationship between psychopathology and race can guide ethnic identity research for school absenteeism. Research on anxiety, depression, and disruptive disorders and race variables will be discussed because of their high comorbidity with school refusal behavior.

Research on psychopathology and race is mixed. Some studies find no racial differences (Edman et al., 1998; Siegel, Aneshensel, Taub, Cantwell, & Driscoll, 1998) in prevalence rates for psychological disorders in youth. Last and Perrin (1993) examined differences in anxiety disorder symptomatology of African American (n = 30) and European American (n = 139) children aged 5-17 years. Clinicians rated the severity of European American children with a primary anxiety disorder diagnosis higher than African American children. The two groups did not differ significantly in duration and type of disorder. African American children had higher prevalence rates of simple phobia and lifetime prevalence rates of PTSD, whereas European American children had

higher rates of panic, obsessive-compulsive disorder, and social phobia. The two groups did not differ on prevalence rates of mood or behavioral disorders (Last & Perrin, 1993). Ginsburg and Silverman (1996) compared phobic and anxiety disorders in 99 Hispanic and 143 European American youth. A primary diagnosis of separation anxiety disorder was more often diagnosed in Hispanic youth compared to European American youth.

Internalizing symptoms are more often reported by European American youth compared to African American, Asian American, and Native Hawaiian youth (Kim & Chun, 1993). Other researchers find internalizing symptoms are more often found in Hispanic youth and this elevation is consistent throughout childhood and adolescence (Ginsburg & Silverman, 1996; Glover, Pumeriega, Holzer, Wise, & Rodriguez, 1999; Gross et al., 2006; McLaughlin, Hilt, Nolen-Hoeksema, 2007). Hispanic cultures also tend to associate a negative stigma to mental illness such as anxiety (Varela & Hensley-Maloney, 2009). Psychopathology is seen as inferiority, lack of will power, and should result in isolation. Culturally benign terms such as *nervios* are preferred to the traditional mental health term of anxiety. Parenting styles and family environment variables such as control, warmth, and acceptance have found to differ in their interaction with anxiety disorders in Hispanic families compared to European American families (Varela et al., 2009).

Some researchers find lower prevalence rates of depression in children of color (Allen & Mitchell, 1998; Yao, Solanto, & Wender, 1988) but others find higher rates of depressive symptomatology in African American, Hispanic, and Asian-American youth (Roberts, Chen, & Solovitz, 1995; Roberts, Roberts, & Chen, 1997; Sue & Zane, 1985). Some studies indicate that African American adolescents have higher rates of depression

than European Americans (Franko et al., 2005; Kistner, David, & White, 2003). Nguyen, Huang, Arganza, and Liao (2007) examined 1,189 youth who were predominately European American (31.3%), Hispanic (27.1%), Native Hawaiian (26.2%), Asian (8.2%), or African American (7.2%). Hispanic or Native Hawaiian youth were diagnosed with depression or dysthymia more than European American youth. In clinical settings, African American at-risk youth have lower levels of depression (Stiffman, Cheuh, & Earls, 1992). However, several large studies have found no ethnic differences in depressive symptomatology (Cole, Martin, Peeke, Henderson, & Harwell, 1998; Costello et al., 1996; Franko et al., 2005).

Higher conduct disorder symptomatology has been found in African American children (Costello, Compton, Keeler, & Angold, 2003). African American youth were also diagnosed more often with conduct disorder in inpatient settings than European Americans (Delbello, Lopez-Larson, Soutullo, & Strakowski, 2001; Fabrega, Ulrich, & Messich, 1993). Nguyen, Huang, Arganza, and Liao (2007) found that disruptive disorders were more often diagnosed in African American and Native Hawaiian youth. African American males report higher levels of aggression (McLaughlin, Hilt, & Nolen-Hoeksema, 2007).

Prevalence of ADHD is fairly equal among many different countries (Barkley, 2003). Langsdorf and colleagues (1979) found that African American students had higher levels of hyperactivity than would normally be seen in the population. Levels of hyperactivity were less than expected for Mexican Americans. Hyperactivity was uniformly distributed for European American students. Cuffe, Moore, and McKeown (2005) found more ADHD symptoms in European American and African American

children than Hispanic children. Both studies used abbreviated behavioral checklists and did not differentiate SES and ethnicity. Teacher reports and behavioral observations of ADHD symptomatology also differ across ethnicity, which may explain some differences.

Determining racial differences in psychological disorders is a starting point for school refusal behavior research. More research is needed to understand the role ethnicity plays in psychological well-being because research findings vary regarding ethnicity and psychopathology. Ethnic identity measures these differences in more detail than simple reporting of racial demographics. Ethnic identity is the next step to understand true differences in psychopathology and within group variance. Ethnic identity influences other disorders comorbid with school refusal behavior, so it should be explored with respect to nonattendance and was a major focus of the present study.

Purpose of the Study

The present study investigated contextual variables related to school refusal behavior among a representative sample of youth with attendance difficulties. Researchers have urged further exploration of broad contextual variables such as cultural and community factors to improve continuity across disciplines (Kearney, 2008a; 2008b; Lyon & Cotler, 2009). The first aim of this study was to identify level of ethnic identity in youth with school refusal behavior in clinic and community settings. Level of ethnic identity with a particular group was expected to be equal across these settings (Parham, 1989; Phinney, 1990, 1996; Phinney & Ong, 2007). Youth were expected to be in the early stages of ethnic identity formation.

The second aim of this study was to determine the relationship between functions of school refusal behavior and level of ethnic identity. Strong ethnic identity has shown to promote academic success, involvement in extracurricular activities, and school climate (Davalos, Chavez, & Guardiola, 1999; Esparza & Sánchez, 2008). These variables also relate to school refusal behavior (Brookmeyer et al., 2006; Epstein et al., 2002; South, Haynie, & Bose, 2007; Weisman & Gottfredson, 2001). No research exists examining the relationship between ethnic identity and functions for nonattendance. Similar levels of ethnic identity among the four functions of school refusal behavior were expected.

The third aim of this study was to examine the relationship between psychopathology associated with school refusal behavior and level of ethnic identity. Youth who refuse school exhibit substantial psychopathology (Egger, Costello, & Angold, 2003; Kearney, 2001; Kearney & Albano, 2004; McShane, Walter, & Ray, 2001). Higher levels of ethnic identity are related to less psychopathology (Abu-Rayya, 2006; Marie et al., 2008) and mixed or lower levels of ethnic identity are related to greater psychopathology (Brown, 2001; Gibbs, 1987; Milan & Keily, 2000; Sue & Sue, 2003). Higher levels of ethnic identity were thus expected to be related to lower levels of psychopathology associated with school refusal behavior.

The fourth aim of this study was to examine the relationship between familial interaction and ethnic identity within a school refusal behavior sample. Young adolescents are in the early stages of ethnic identity development and parent ethnic identity influences youth ethnic identity during this stage (Phinney, 1996; Phinney & Ong, 2007; Phinney, Romero, Nava, & Huang, 2001). Comparisons between parent and

youth ethnic identity were made. The parent-youth interaction was examined because beliefs and traditions prevalent in a youth's environment influence ethnic identity (Phinney, 1989; Phinney, 1996; Phinney & Tarver, 1988). Younger youth's level of ethnic identity was expected to be similar to their parents. Older youth's level of ethnic identity was expected to be less similar to their parents because they have been exploring their ethnic identity longer and may be differentiating themselves from their parents.

Family environment variables such as enmeshment, conflict, isolation, and lack of communication have also been associated with nonattendance (Bernstein, Svingen, & Garfinkel, 1990; Hansen, Sanders, Massaro, & Last, 1998; Kearney et al., 1995; McShane, Walter, & Rey, 2004). Family variables have also been found to be associated with ethnic identity. Maintenance of culture in the family was found to positively influence adolescent ethnic identity (Phinney, Romero, Nava, & Huang, 2001). Youth that reported high levels of ethnic identity were expected to have families that promote intellectual and cultural activities more than youth with lower levels of ethnic identity.

Lastly, this study examined youth with school refusal behavior in clinic and community settings. One criticism of the literature is that researchers in psychology, social/criminal justice, and education use varying terminology and approaches (Kearney, 2008a). A representative sample of attendance difficulties and youth characteristics may help bridge the gap between disciplines by examining youth from different settings. Research regarding youth who seek treatment at specialized clinics versus community settings is relatively sparse. Some research indicates that these populations differ in symptomatology and pathology (Egger et al., 2003; Kennedy, 1965; Place, Hulsmeier, Davis, & Taylor, 2000) but others find no differences (McShane, Walter, & Ray, 2001;

2004). Psychopathology and school refusal behavior functions were examined across settings to determine if unique and significant differences exist. Youth referred to a clinic setting were expected to endorse more internalizing symptoms and youth referred to community settings were expected to endorse more externalizing symptoms.

The present study also examined ethnic group distributions across assessment settings. Minorities are underrepresented in mental health settings and specialized school refusal behavior clinics (Bernstein & Garfinkel, 1986; Bernstein et al., 1997; Hansen et al., 1998; Kearney, 2001). Higher percentages of the ethnic majority group (European Americans) were expected to be referred to the clinic setting and higher percentages of non-majority ethnic groups (African Americans, Hispanics, and Asian Americans) were expected to be referred to the community setting.

Findings from the present study contribute to an interdisciplinary model by providing a framework of behaviors and contextual factors that influence nonattendance across settings. Valuable information about how the strength of an individual's traditions and beliefs influence nonattendance was provided by addressing ethnic identity rather than race. The present study provided information on broad contextual variables, such as ethnic identity and family, at the primary and secondary level of the model proposed by Kearney (2008). The present study may also serve as a guide for future research in psychology, education, and social/criminal justice to address ethnicity at more complex levels.

Hypotheses

The first hypothesis was composed of three parts. Hypothesis 1a was that scores of youth ethnic identity on the Multigroup Ethnic Identity Measure (MEIM; Phinney,

1992) would be equivalent across the clinic and community samples. Hypothesis 1b was that scores of parent ethnic identity on the MEIM would be equivalent across the clinic and community samples. This was based on literature that ethnic identity is a developmental and progressive process that changes over time (Parham, 1989; Phinney, 1990, 1996; Phinney & Ong, 2007). Hypothesis 1c was that more youth in the community sample would identify their ethnicity as part of an ethnic minority group than youth in the clinic sample. This was based on literature reporting a higher percentage of European American youth referred to specialized clinic settings for school refusal behavior (Bernstein & Garfinkel, 1986; Bernstein et al., 1997; Hansen et al., 1998; Kearney, 2001). Minorities also are often underrepresented in clinic settings (Kearney, 2001).

Hypothesis 2 was composed of two parts. Hypothesis 2a was that ethnic identity scores would be equivalent across the primary functions of school refusal behavior. No evidence supports higher or lower levels of ethnic identity with respect to functions of school refusal behavior. Reduced psychopathology, however, was hypothesized for youth with higher levels of ethnic identity. Hypothesis 2b was that youth who reported higher scores of ethnic identity would have lower scores of self- and parent-reported internalizing and externalizing symptomatology as measured by the Revised Child Anxiety and Depression Scale (Chorpita, Moffitt, Umemoto, & Francis, 2000) and Conner's Parent Rating Scales (Conners, Parker, Sitarenios, & Epstein, 1998). This was based on literature that strong ethnic identity serves as a protective factor against psychopathology (Abu-Rayya, 2006; Roberts & Roberts, 2007; Marie, Fergusson, & Boden, 2008).

Hypothesis 3 was composed of two parts. Hypothesis 3a was that ethnic identity scores would be equivalent between parents and younger youth (age 10-12 years) but not equivalent between parents and mid-range and older youth (age 13-14 and age 15-16 years). This hypothesis was based on literature that younger adolescents beginning their ethnic identity process turn to familial and societal contexts for information, whereas older youth have already spent time searching their ethnicity and are in a stage of exploration (Phinney, 1989, 1996; Phinney & Tarver, 1988). Hypothesis 3b was that higher scores on the Family Environment Scale intellectual-cultural subscale (Moos & Moos, 1981) would be associated with higher ethnic identity. Participation in activities and traditions and sharing values and attitudes of that ethnic group are associated with ethnic identity (Phinney, 1990; White & Burke, 1987). Higher levels on this scale were expected because the intellectual-cultural subscale of the FES measures the extent to which a family has political, intellectual, and cultural interests (Moos et al., 1981).

Hypothesis 4 was composed of three parts. Hypothesis 4a was that youth in the community setting would exhibit higher scores of positively reinforced nonattendance and that youth in the clinic setting would exhibit higher scores of negatively reinforced nonattendance as measured by the School Refusal Assessment Scale-Revised (SRAS-R; Kearney, 2002, 2006). This hypothesis was based on literature reporting differences in school-related behavioral variables in community and clinic settings (Kennedy, 1965). Youth treated in community settings had dysfunctional parent relationships and chronic school refusal behavior (Kennedy, 1965). Hypothesis 4b was that youth in the clinic setting would have higher anxiety and depression scores on the Revised Child Anxiety and Depression Scale (Chorpita, Moffitt, Umemoto, & Francis, 2000) than youth in the

community setting. Hypothesis 4c was that parents of youth in the clinic sample would report higher scores of internalizing symptomatology than the community sample and that parents of youth in the community sample would report higher scores of externalizing symptomatology on the Conner's Parent Rating Scales (Conners, Parker, Sitarenios, & Epstein, 1998) than the clinic sample. These two hypotheses were based on literature indicating higher levels of internalizing symptoms in clinic samples and higher levels of externalizing symptoms in community samples (Egger, Costello, & Angold, 2003; Kearney & Albano, 2004; McShane, Walter, & Ray, 2001).

CHAPTER 3

METHODOLOGY

Participants

Community sample. Participants from the Clark County School District (CCSD) Truancy Court and Truancy Diversion programs were considered the community sample. Initially, 191 participants (M age = 13.8; SD = 1.7) were recruited from the CCSD Truancy Court and Truancy Diversion programs. Youth aged 16-17 years were removed from the community sample to match the clinic sample regarding age. The final community sample was thus comprised of 154 participants (M age = 13.1; SD = 1.2). This sample was 50.6% male. Youth were Hispanic (68.4%), European American (10.5%), African American (9.2%), multiracial (5.3%), other (4.6%), Asian American (1.3%), and Native American (0.7%).

The community sample consisted of youth referred to the CCSD Truancy Court or the CCSD Truancy Diversion Program. Youth referred to CCSD Truancy court (n = 46) were aged 11-15 years (M = 14.0; SD = 1.1) and were 50% male. Youth were Hispanic (65.2%), African American (10.9%), multiracial (10.9%), European American (8.7%), Native American (2.2%), and other (2.2%). Youth referred to the CCSD Truancy Diversion program (n = 108) were aged 11-15 years (M = 12.7; SD = .9) and 50.9% male. Youth were Hispanic (69.8%), European American (11.3%), African American (8.5%), Other (5.7%), Multiracial (2.8%), and Asian American (1.9%).

Clinic sample. Participants from the UNLV Child School Refusal and Anxiety Disorders Clinic were considered the clinic sample. The clinic sample (n = 28) was aged

10-16 years (M age = 12.5; SD = 1.8) and 60.7% male. Youth were European American (67.9%), Hispanic (21.4%), Multiracial (7.1%), and Other (3.6%).

Measures

Parent Measures

Demographic Sheet. Parents provided demographic and other information on the measure in Appendix A.

Conners Parent Rating Scale – Revised Long (CPRS-R:L; Conners, 1997; Conners, Sitarenios, Parker, & Epstein, 1998). The CPRS-R:L is an 80-item measure of childhood behavior problems. Parents were asked on a 4-point scale (0 = not true at all, 1 = just a little true, 2 = pretty much true, 3 = very much true) to rate how true each behavior was within the past month. Subscales include: oppositional, hyperactive-impulsive, perfectionism, psychosomatic, attention deficit hyperactivity disorder, cognitive problems, anxious-shy, social problems, DSM-IV symptoms subscales, and global index. Norms from parents of 2200 students aged 3-17 years have been established. Subscales display excellent internal consistency with coefficient alphas ranging from .75-.94 for males and .75-.93 for females. Six-week test-retest reliabilities for the subscales were .42-.78. No gender differences (NNFI = .988 and CFI = .989) or age differences (NNFI = .956 and CFI = .962) in the pattern of intercorrelations were found. This measure was administered to assess psychopathology and took approximately 15 minutes to complete.

Family Environment Scale (Appendix B) (FES; Moos & Moos, 1981). The FES is a 90-item true-false measure of family social environment. Parents rated items based on their views of their family and not opinions of other family members. Items

relate to 3 dimensions: relationships, personal growth, and system maintenance. Each dimension contains several subscales. Only the intellectual-cultural orientation subscale was examined in this study and is part of the personal growth dimension. The intellectual-cultural orientation scale measures the extent to which a family has political, intellectual, and cultural interests

For this study, the FES real form (Form R) was used for current functioning and relationship with school refusal behavior. Normative data from 1432 non-distressed families and 789 distressed families are available for Form R. Two- and four-month test-retest reliabilities for the subscales range from .70-.91 (Moos, 1990). Cronbach's alpha for the subscales range from .61-.78, suggesting adequate internal consistency (Moos, 1990). A Spanish version of this measure was also available. This scale was administered to parents and took approximately 15 minutes to complete.

Psychometric properties for use with ethnic diverse populations found response differences on the FES. Means and standard deviations were calculated for African American and Latino families and compared to normative data for non-distressed families. The author suggests that these results should be interpreted with caution because the sample size was small, drawn from primarily middle class families, and not matched on family size or SES. The African-American and Latino families, however, reported higher levels of achievement orientation, moral-religious emphasis, organization, and control. These families reported lower levels of expressiveness and independence (Moos, 2009).

School Refusal Assessment Scale-Parent – Revised (Appendix C) (SRAS-P-R; Kearney, 2002, 2006). The SRAS-P-R is a 24-item measure of school refusal behavior

obtained from parents or caregivers of youth refusing school. Six items are dedicated to each function of school refusal behavior: (1) avoidance of stimuli provoking negative affectivity (ANA), (2) escape from aversive social and/or evaluative situations (ESE), (3) attention-seeking (AGB), and (4) tangible reinforcement (PTR). Functions 1 and 2 are negative reinforcers for school refusal and functions 3 and 4 are positive reinforcers for school refusal. Each item is rated on a 1-6 scale (1 = never to 6 = always). A mean item score is derived for each functional condition. The highest subscale is considered the primary reason for school refusal. Unanswered items are not counted. If mean scores for two functions are within 0.25 points of one another, then the functions are considered equivalent. This scale was administered to parents to assess the function of a youth's school refusal behavior and took approximately 10 minutes to complete.

The scale has shown adequate 7-14 day test-retest (mean $r = .67$) and interrater (mean $r = .54$) reliability (Kearney, 2002). A factor analysis established construct validity. Negative reinforcement functions were strongly associated with internalizing symptoms and positive reinforcement functions were strongly associated with externalizing symptoms (Kearney, 2002).

A confirmatory factor analysis of the SRAS-P-R showed a four-factor model consistent with the 4 functions of school refusal behavior (Kearney, 2006). However, items 18, 20, and 24 of the scale detracted from the other factors and caution is advised when using these items in interpretation. These items may be removed during analysis because a sufficient number of items remain for adequate interpretation (Kearney, 2006). When the original 1993 version of the scale was examined, similar results were found in a multiethnic sample (Higa, Daleiden, & Chorpita, 2002). Higa and colleagues (2002)

suggested more information be obtained regarding combining scores from multiple reporters (e.g., child and parent) and weighted scores may be considered.

A confirmatory factor analysis was also conducted with a diverse community sample of 216 youth and their parents (Haight, Kearney, Hendron, & Schafer, 2011). Participants were Hispanic (60.6%), European-American (11.6%), African-American (10.2%), multiracial (5.6%), Native American (2.3%), Asian-American (0.9%), and other (6.5%) or unreported (2.3%). The SRAS-P-R retained the four-factor structure.

Youth Measures

Everyday Discrimination Measure (Appendix D). A 9-item measure was designed to assess everyday racial discrimination because no published brief measures of racial discrimination for adolescents were available. The 9 items were based on work from Essed (1991) and Williams, Yu, Jackson, and Anderson (1997). Youth were asked on a 5-point scale (1 = never, 2 = hardly ever, 3 = not too often, 4 = fairly often, 5 = very often) how often the following statements happened to them in their everyday life. Higher scores indicate greater perceived everyday discrimination. The measure took approximately 5 minutes to complete.

Revised Child Anxiety and Depression Scale (Appendix E) (RCADS; Chorpita, Yim, Moffitt, Umemoto, & Francis, 2000). The RCADS is a 47-item measure of depression and anxiety in children. Items are consistent with DSM-IV criteria for separation anxiety disorder (SAD), social phobia (SP), generalized anxiety disorder (GAD), obsessive-compulsive disorder (OCD), panic disorder (PD), and major depressive disorder (MDD). Items were originally adapted from the Spence Children's Anxiety Scale (SCAS) with additional items to assess for excessive worry and

depression. Youth rated each item on a 0-3 scale (0 = never, 1 = sometimes, 2 = often, 3 = always). The RCADS took approximately 15 minutes to complete.

Chorpita and colleagues (2000) initially examined the RCADS with 56 items (38 from the SCAS and 11 additional items). The subscales showed good internal consistency with coefficient alphas ranging from .61-.79. The authors felt that the generalized anxiety items showed problems of heterogeneity. This subscale was revised and resulted in a coefficient alpha of .83. An exploratory factor analysis revealed a 6-factor solution for the scale. After removal of items, coefficient alphas ranged from .73-.82. A second study was conducted using the new 47-item measure with 246 children and adolescents. The sample was ethnically diverse (Japanese American = 28.2%; Filipino = 13.2%; Hawaiian = 12.4%; Chinese American = 8.4%; Caucasian = 8.1%; multi-ethnic = 16.8%; other = 12.8%) and gender was represented fairly equally (male = 45.6%). Good internal consistency was demonstrated with coefficient alphas ranging from .71-.85. One week test-retest reliabilities ranged from .64-.80 for boys and .64-.87 for girls.

The RCADS correlated with the Children's Depression Inventory (CDI; Kovacs, 1985) and the Child Manifest Anxiety Scale (RCMAS; Reynolds & Richmond, 1978). The CDI is a widely used measure of depression in youth. The RCMAS, a popular self-report measure of youth anxiety, has subscales for physiological anxiety (RCMAS-P), worry and oversensitivity (RCMAS-W), and concentration anxiety (RCMAS-C) (Reynolds & Paget, 1983). The RCADS MDD scale correlated highly with the CDI ($r = .70, p < .01$). The RCADS MDD subscale correlated in the expected direction with the RCMAS-P and RCMAS-C subscales.

School Climate Survey-Revised Edition (SCS-RE; Haynes, 1985). The SCS-RE is a 42-item measure of school climate. Youth were asked on a 5-point scale (SA = strongly agree, A = agree, NS = not sure, D = disagree, and SD = strongly disagree) to rate how they feel about their school. Six dimensions of school climate can be obtained: sharing of resources, order and discipline, parent involvement, school building, student interpersonal relations, and student-teacher relations. Sharing of resources measures the student's perception that there is equal opportunity for students to participate in school activities, and have access to materials and equipment. Order and discipline measures student behaviors such as fighting and safety. Parental involvement measures student perception of parent(s) involvement in school activities. School building measures the overall condition of the school and materials inside. Student interpersonal relations and student-teacher relations measures caring, respect, and trust among students and teacher-students.

The sharing of resources ($r = .73$), order and discipline ($r = .67$), parental involvement ($r = .68$), and school building ($r = .70$) subscales have moderate reliability. The student interpersonal relations ($r = .90$) and student-teacher relations ($r = .89$) subscales have high reliability. Items 20 and 41 of the order and discipline subscale, item 9 of the parental involvement subscale, and items 15 and 34 of the school building subscale were not included in reliability analyses because they are new items. No psychometric properties regarding use of this scale with ethnically diverse participants was available. This scale took approximately 10 minutes to complete.

School Refusal Assessment Scale-Child –Revised (Appendix F) (SRAS-C-R; Kearney, 2002, 2006). The SRAS-C-R is a 24-item measure of school refusal behavior

obtained from parents or caregivers of youth refusing school. Six items are dedicated to each function of school refusal behavior: (1) avoidance of stimuli provoking negative affectivity (ANA), (2) escape from aversive social and/or evaluative situations (ESE), (3) attention-seeking (AGB), and (4) tangible reinforcement (PTR). Functions 1 and 2 are negative reinforcers for school refusal and functions 3 and 4 are positive reinforcers for school refusal. Each item is rated on a 0-6 scale (1 = never to 6 = always). A mean item score is derived for each functional condition. The highest subscale is considered the primary reason for school refusal. Unanswered items are not counted. If mean scores for two functions are within 0.25 points of one another, then the functions are considered equivalent. This scale was administered to youth to assess function of school refusal behavior and took approximately 10 minutes to complete.

The scale has shown adequate 7-14-day child test-retest reliability (mean $r = .68$) (Kearney, 2002). Construct and concurrent validity was also established. The current 24-item version of the SRAS-C-R significantly correlated with the original 16-item version of the SRAS-C (mean of $r = .68$). A factor analysis established construct validity. Negative reinforcement functions were strongly associated with internalizing symptoms and positive reinforcement functions were strongly associated with externalizing symptoms (Kearney, 2002).

A confirmatory factor analysis on the SRAS-C-R showed a four-factor model that is consistent with the 4 functions of school refusal behavior (Kearney, 2006). Items 18, 20, and 24 of the scale detracted from the other factors and caution is advised when using these items in interpretation. These items may be removed during analysis since sufficient numbers of items remain for adequate interpretation (Kearney, 2006). When

the original 1993 version of the scale was examined, similar results were found in a multiethnic sample (Higa, Daleiden, & Chorpita, 2002). Higa and colleagues (2002) suggested more information be obtained regarding combining scores from multiple reporters (e.g., child and parent) and weighted scores may be considered.

A confirmatory factor analysis was also conducted with a diverse community sample of 216 youth and their parents (Haight, Kearney, Hendron, & Schafer, in press). Participants were Hispanic (60.6%), European-American (11.6%), African-American (10.2%), multiracial (5.6%), Native American (2.3%), Asian-American (0.9%), and other (6.5%) or unreported (2.3%). Results mirrored previous studies with clinical samples (Kearney, 2002, 2006; Kearney & Albano, 2004). The SRAS-C-R retained the four-factor structure.

Measures Administered to Parents and Youth

Multigroup Ethnic Identity Measure (Appendix G) (MEIM; Phinney, 1992).

The MEIM is a widely used measure of which ethnic group an individual identifies with and the impact of ethnicity on a person's life. The scale was designed for adolescents and young adults and has shown good reliability and validity for many age and ethnic groups (Phinney, 1992; Roberts, Phinney, Masse, Chen, Roberts & Romero, 1999). The measure consists of 15 questions answered on a combination of response formats including questions answered on a 4 point-Likert scale, and by checkmark and fill-in-the-blank.

The MEIM was designed to measure two aspects of ethnic identity: (1) ethnic identity search (developmental and cognitive component) and (2) affirmation, belonging, and commitment (affective component). Five items comprise the ethnic identity search

factor and 7 questions comprise the affirmation, belonging, and commitment factor. The remaining three items are used for ethnic categorization and identity of youths and their parent. The author has also translated the measure into Spanish but no reliability data are available. The scale took approximately 5 minutes to complete.

Roberts and colleagues (1999) examined the factor structure of the MEIM across 5423 middle school students. The sample was ethnically diverse and gender was represented equally (female = 49%). Twenty distinctive ethnic groups were defined and the largest groups were: African American (n = 1,237), Central American (n = 253), Mexican American (n = 755), European American (n = 755), Indian American (n = 188), and Chinese American (n = 177). A confirmatory factor analysis was conducted with each of the three largest ethnic groups (African American, Mexican American, and European American) and a similar two-factor structure (identity search and affirmation, belonging, and commitment) was supported with all groups.

Procedure

Community sample. The community sample was obtained from two different community truancy programs: Truancy Court and Truancy Diversion. The Truancy Court program involves youths petitioned by the Clark County School District (CCSD) for truancy who are legally mandated to attend court with their parent or legal guardian. Each youth was given documentation of the charges set forth, including the number of accrued unexcused absences, and pled “guilty” or “not guilty” to charges of truancy. Youths could also choose to be represented by a state public defender free of charge. Youths who pled “not guilty” were also appointed a public defender. Youths that pled “guilty” were sentenced by the judge to daily attendance monitoring sheets that must be

completed by each teacher and include attendance records and comments on work progress and motivation in the classroom. The judge in the Truancy Court program was a Clark County family court judge. Truancy Court was in session on Thursdays and Fridays in the Family Court Services building in Las Vegas, Nevada.

The judges involved in this program agreed to allow youths to substitute 2 hours of community service for completion of the measures. If the youth and parent/guardian agreed to participate, then a UNLV graduate or undergraduate student representative provided a brief explanation of the study in a private room adjacent to the courtroom. A UNLV representative told the youth and parent/guardian that all information was confidential and that their name would not be associated with their answers. They were also informed that all information is coded by number into a database. The UNLV representative then explained the informed consent with the parent/guardian and assent with the youth. They were instructed that the court does not have access to the individual information provided in the study. Parent/guardian and youth completed the dependent measures after signing the informed consent and assent. The UNLV representative was available at all times to answer participant questions. All forms were translated into Spanish if needed and a Spanish interpreter was provided to assist in completion of the measures. This project is ongoing and IRB-approved (protocol #0802-2620).

Data were also obtained from youths and parents at the CCSD Truancy Diversion program. The Truancy Diversion program is facilitated by the Court Appointed Special Advocates (CASA) program. CASA is a group that advocates on behalf of children in Nevada. Early development of the truancy diversion program was in 8 high-risk middle schools in the Clark County School District. The program has now expanded to 10 high-

risk middle schools and 2 high-risk high schools. Middle school staff identified 15-20 students at each school with problematic attendance. Youths and parent/guardians met once a week with a “judge” who discussed their case. Judges were volunteer legal professionals from the community such as lawyers and family court judges. Attendance, grades, and other familial issues were addressed and monitored in these meetings. An appointed CASA family advocate followed the cases at each school. Counseling groups and tutoring assistance were provided depending on the needs of the youth.

Parent/guardian and youth enrolled in the program participated in the research project at entry into the program. If the youth and parent/guardian agreed to participate, then a UNLV graduate or undergraduate student representative provided a brief explanation of the study. A UNLV representative told the youth and parent/guardian that all information was confidential and that their name would not be associated with their answers. They were also informed that all information is coded by number into a database. The UNLV representative then explained the informed consent with the parent/guardian and assent with the youth. They were instructed that the school does not have access to the individual information provided in the study. Parent/guardian and youth completed the dependent measures after signing the informed consent and assent. The UNLV representative was available at all times to answer participant questions. All forms were translated into Spanish if needed and a Spanish interpreter was provided to assist in completion of the measures. This project is ongoing and IRB- (protocol # 0801-2585) and CCSD-approved (Application Number 58-2008).

Clinic sample. Youth were referred to the UNLV Child School Refusal and Anxiety Disorders Clinic by CCSD staff and other community agencies for school refusal

behavior. Youth referred to the clinic live in Las Vegas and the surrounding areas (e.g., Henderson, Boulder City). The UNLV Child School Refusal and Anxiety Disorders Clinic is a specialized clinic for school refusal and other anxiety-based disorders such as selective mutism, social phobia, and generalized anxiety disorder. The clinic operates during the 9-month academic year. Therapists are advanced clinical psychology graduate students in their third year of clinical training or beyond. An initial assessment was scheduled by the therapist if the referral was determined appropriate for the clinic. Initial assessments were approximately 1.5-2 hours long and included parent and youth structured interviews, behavioral observations, and self-report measures completed by the parent/legal guardian and youth. The therapist and an undergraduate research assistant were available to answer questions and provide assistance. The parent/legal guardian read and signed a consent form regarding clinic procedures during the initial assessment. The parent/legal guardian consented for participation in research. Procedures and measures did not deviate from normal clinic procedures. IRB approval was obtained to examine ongoing and archival records at the clinic (protocol #0802-2620).

Data Analyses

General information

Means, standard deviations, and frequencies were derived for demographic and/or youth ethnic identity variables. Differences in gender, age, and race across the community and clinic samples were examined via chi-square analysis, t-tests, an analysis of variance (ANOVA), and a multivariate analysis of variance (MANOVA). Combined youth-parent SRAS-R scores were employed because separate analyses of child and parent SRAS-R scores revealed no difference in statistical results from the combined

scores. The primary function for school refusal behavior was determined via the highest item mean score and was utilized for Hypothesis 2a. For hypothesis 3a, 3 age groups were utilized: 10-12 years (younger youth), 13-14 years (mid-range youth), and 15-17 years (older youth).

Hypothesis 1

Hypothesis 1a was that youth ethnic identity scores would be equivalent across the clinic and community samples. An independent sample t-test was thus conducted. Separate independent sample t-tests were conducted to account for ethnic identification with ethnic majority and ethnic minority groups. Hypothesis 1b was that parent ethnic identity scores would be equivalent across the clinic and community samples. An independent sample t-test was thus conducted. A Bonferroni adjustment was used to reduce Type I error.

Hypothesis 1c was that more youth in the community sample would identify their ethnicity as part of an ethnic minority group than youth in the clinic sample. A 2x7 chi-square analysis was initially conducted across assessment setting (clinic and community) and question 13 of the MEIM (7 categories of ethnicity). However, the assumption of minimum expected cell frequency was violated. Ethnic identity was thus recoded into ethnic majority (European American) and ethnic minority groups (non-European American). A 2 x 2 chi-square analysis was then conducted to determine if the sample differed in regards to ethnicity.

Hypothesis 2

Hypothesis 2a was ethnic identity scores would be equivalent across the primary functions of school refusal behavior. A multivariate analysis of variance (MANOVA)

was thus conducted. Hypothesis 2b was that youth who reported higher scores of ethnic identity would have lower scores of self- and parent-reported internalizing and externalizing symptomatology as measured by the RCADS and CPRS. Stepwise multiple regressions were conducted to determine which internalizing and externalizing symptomatology best predicted each ethnic identity variable. Dependent variables were the three youth ethnic identity variables (total ethnic identity, identity search, and affirmation, belonging, and commitment) and predictor variables were RCADS and CPRS subscales.

Hypothesis 3

Hypothesis 3a was that ethnic identity scores would be equivalent between parents and younger youth (age 10-12 years) but not equivalent between parents and mid-range and older youth (age 13-14 and age 15-17 years). A matched sample t-test with corresponding parent and youth ethnic identity variables (total ethnic identity, identity search, and affirmation, belonging, and commitment) was thus conducted.

Hypothesis 3b was that higher scores on the FES intellectual-cultural subscale would be associated with higher ethnic identity scores. Simultaneous multiple regression analyses were thus conducted with the intellectual-cultural subscale of the FES as the dependent variable and parent and youth ethnic identity variables as predictors.

Hypothesis 4

Hypothesis 4a was that youth in the community setting would exhibit higher scores of positively reinforced nonattendance and youth in the clinic setting would exhibit higher scores of negatively reinforced nonattendance. An independent sample t-test was thus conducted. A Bonferroni adjustment was used to reduce Type I error

Hypothesis 4b was youth in the clinic setting would have higher RCADS subscale scores than youth in the community setting. An independent sample t-test was thus conducted. A Bonferroni adjustment was used to reduce Type I error. Hypothesis 4c was that parents of youth in the clinic sample would report higher scores of internalizing symptoms on the CPRS and parents of youth in the community sample would report higher scores externalizing symptoms on the CPRS. An independent sample t-test was thus conducted. A Bonferroni adjustment was used to reduce Type I error.

Exploratory Analyses

School climate and perceived daily discrimination were examined on an exploratory basis. A Pearson product moment correlation was initially conducted to determine the relationship between school climate and ethnic identity. A subsequent simultaneous multiple regression analysis was conducted to determine which of the 6 school climate variables predicted ethnic identity. A Pearson product moment correlation was initially conducted to determine the relationship between school climate and function for nonattendance. A subsequent simultaneous multiple regression analysis was conducted to determine which of the 6 school climate variables predicted function for nonattendance.

A Pearson product moment correlation was initially conducted to determine the relationship between everyday discrimination and ethnic identity. A subsequent simultaneous multiple regression analysis was conducted to determine which of the 3 youth ethnic identity variables predicted everyday discrimination. A stepwise multiple regression was conducted to examine which school climate variables best predicted perceived everyday discrimination.

The relationship between conflict and differences in parent and child ethnic identity scores were examined on an exploratory basis. A difference score was calculated between parent and child on the 3 ethnic identity variables (total ethnic identity, identity search, and affirmation, belonging, and commitment). Simultaneous multiple regression analyses were thus conducted with the conflict subscale of the FES as the dependent variable and parent and youth ethnic identity difference variables as predictors.

CHAPTER 4

RESULTS

Demographic variables

Chi-square analysis revealed no significant gender distribution difference between the clinic and community sample (Table 3). An independent sample t-test revealed no significant age difference between the clinic and community sample. Chi-square analysis revealed that the community sample was more diverse than the clinic sample. More youth in the community sample identified their ethnicity as part of an ethnic minority group than youth in the clinic sample [$\chi^2 (1, n = 168) = 19.69, p < .001, \phi = .37$].

Independent sample t-tests revealed no significant gender differences on youth total ethnic identity, identity search, and affirmation, belonging, and commitment. A one-way analysis of variance (ANOVA) revealed no significant age differences for the three age groups (10-12, 13-14, and 15-16 years) on youth total ethnic identity, identity search, and affirmation, belonging, and commitment. A MANOVA was conducted to examine racial differences but the assumption of homogeneity of variance and equality of variance was violated. Youths were thus divided into ethnic majority (European American) and ethnic minority (non-European American) group classifications. Youth whose ethnic identity was affiliated with an ethnic minority group scored higher on total ethnic identity ($t (166) = 2.32, p = .02, \eta^2 = .03$) and identity search ($t (166) = 2.58, p = .01, \eta^2 = .04$) than youth whose ethnic identity was affiliated with the ethnic majority group. No significant differences were found for youth affirmation, belonging, and commitment and affiliation with respect to ethnic majority or ethnic minority group.

Hypothesis 1

Hypothesis 1a was that youth ethnic identity scores would be equivalent across the clinic and community samples (Table 4). A significance level of .02 was used to evaluate all results to control for Type I errors. An independent sample t-test revealed that youth in the community sample scored higher on identity search ($t(171) = 2.96, p = .003, \eta^2 = .05$) than youth in the clinic sample. No significant differences were found for youth total ethnic identity, and affirmation, belonging, and commitment. Differences in ethnic identity scores were also examined by ethnic group affiliation. Youth in the community sample that identified their ethnicity as belonging to an ethnic minority group scored higher on total ethnic identity ($t(138) = 2.52, p = .01, \eta^2 = .04$) and ethnic identity search ($t(138) = 2.42, p = .02, \eta^2 = .04$) than youth in the clinic sample. No differences were found between samples for youth that identified their ethnicity as belonging to the ethnic majority group. Hypothesis 1a was thus partially supported.

Hypothesis 1b was that parent ethnic identity scores would be equivalent across the clinic and community samples (Table 4). A significance level of .02 was used to evaluate all results to control for Type I errors. An independent sample t-test revealed that parents in the community sample reported higher scores of total ethnic identity than parents in the clinic sample ($t(148) = 3.42, p = .001, \eta^2 = .07$). Specifically, parents in the community sample reported higher scores of ethnic identity search ($t(39.1) = 4.76, p < .001, \eta^2 = .37$) and affirmation, belonging, and commitment related to ethnic identity ($t(148) = 2.48, p = .01, \eta^2 = .04$) than parents in the clinic sample. Hypothesis 1b was not supported.

Hypothesis 1c was that more youth in the community sample would identify their ethnicity as part of an ethnic minority group than youth in the clinic sample. Hypothesis 1c was supported [χ^2 (1, n = 168) = 19.69, $p < .001$, phi = .37].

Hypothesis 2

Hypothesis 2a was that ethnic identity scores would be equivalent across the primary functions of school refusal behavior. A MANOVA revealed no difference across school refusal functions regarding parent or youth ethnic identity. Hypothesis 2a was supported.

Hypothesis 2b was that youth who reported higher scores of ethnic identity would have less self- and parent-reported internalizing and externalizing symptomatology (Table 5). A stepwise multiple regression revealed that less cognitive problems/inattention and greater generalized anxiety and perfectionism predicted higher scores of total ethnic identity (F (3, 129) = 5.98, $p = .001$). Greater perfectionism and total anxiety as well as less depression and psychosomatic symptoms predicted higher scores of ethnic identity search (F (4, 128) = 7.26, $p < .001$). Less cognitive problems/inattention and greater generalized anxiety predicted higher scores of affirmation, belonging, and commitment (F (2, 130) = 5.47, $p = .005$). Hypothesis 2b was not supported.

Hypothesis 3

Hypothesis 3a was that ethnic identity scores would be equivalent between parents and younger youth (age 10-12 years) but not equivalent between parents and mid-range and older youth (age 13-14 and age 15-16 years) (Table 6). For youth aged 10-12 years, no significant differences were found across parent and youth scores for total ethnic identity, ethnic identity search and affirmation, belonging, and commitment. For

youth aged 13-14 years, no significant differences were found across parent and youth scores for ethnic identity search. Youth aged 13-14 years did, however, report lower scores on total ethnic identity ($t(74) = -2.84, p = .006, \eta^2 = .10$) and affirmation, belonging, and commitment ($t(74) = -2.90, p = .005, \eta^2 = .10$) than parents. For youth aged 15-16 years, no significant differences were found across parent and youth scores for ethnic identity search. Youth aged 15-16 years did, however, report lower scores on total ethnic identity ($t(23) = -2.27, p = .03, \eta^2 = .18$) and affirmation, belonging, and commitment ($t(23) = -2.24, p = .04, \eta^2 = .18$) than parents. Hypothesis 3a was partially supported.

Hypothesis 3b was that FES intellectual-cultural subscale scores would be associated with higher youth and parent ethnic identity scores (Table 7). A standard multiple regression analysis revealed that youth ethnic identity did not predict FES intellectual-cultural scores. For parent ethnic identity, total ethnic identity predicted the most variance in FES intellectual-cultural scores followed by affirmation, belonging, and commitment as well as ethnic identity search scores ($F(3, 111) = 2.75, p = .05$). Hypothesis 3b was partially supported.

Hypothesis 4

Hypothesis 4a was that youth in the community setting would exhibit greater positively reinforced nonattendance and youth in the clinic setting would exhibit greater negatively reinforced nonattendance (Table 8). A significance level of .01 was used to evaluate all results to control for Type I errors. An independent sample t-test revealed that youth in the clinic sample reported greater negatively reinforced nonattendance than the community sample [(ANA: $t(179) = -10.00, p < .001, \eta^2 = .36$) and ESE: $t(30.5) =$

-4.36, $p < .001$, $\eta^2 = .38$]. Youth in the clinic sample also reported greater attention-seeking or positively reinforced behaviors for nonattendance than the community sample [AGB ($t(179) = -7.04$, $p < .001$, $\eta^2 = .22$)]. No significant differences were found regarding school refusal behavior for tangible reinforcement between the samples.

Hypothesis 4a was partially supported.

Hypothesis 4b was youth in the clinic setting would have higher RCADS anxiety and depression scores than youth in the community setting. A significance level of .006 was used to evaluate all results to control for Type I errors. An independent sample t-test revealed that youth in the clinic sample reported greater separation anxiety ($t(23.6) = -3.04$, $p = .006$, $\eta^2 = .28$) and panic ($t(169) = -2.80$, $p = .006$, $\eta^2 = .04$) scores (Table 9).

Hypothesis 4b was partially supported.

Hypothesis 4c was that parents of youth in the clinic sample would report greater internalizing symptoms than the community sample and that parents of youth in the community sample would report greater externalizing symptoms than the clinic sample (Table 10). A significance level of .004 was used to evaluate all results to control for Type I errors. An independent sample t-test revealed that parents in the clinic sample reported greater anxious-shy symptoms ($t(137) = -3.67$, $p < .001$, $\eta^2 = .09$), psychosomatic symptoms ($t(32.7) = -6.69$, $p < .001$, $\eta^2 = .58$), global index: emotional liability ($t(33.6) = -4.95$, $p < .001$, $\eta^2 = .42$) and general problematic behaviors: global index total ($t(39.7) = -3.29$, $p = .002$, $\eta^2 = .21$) for their youth than parents in the community sample. Hypothesis 4c was partially supported.

Exploratory Procedures

School climate and perceived daily discrimination were examined on an exploratory basis. No significant correlation was found between youth ethnic identity and school climate. A simultaneous multiple regression revealed that the 6 school climate variables did not predict total ethnic identity, identity search, or affirmation, belonging, and commitment.

Significant correlations were found between school climate and function for nonattendance. Function for nonattendance associated with attention-seeking was related to decreased sharing of resources or feeling that school activities, materials, and equipment are not equally available to all students ($r=-.41$, $p=.03$) as well as increased parental involvement ($r=.53$, $p=.004$). Function for nonattendance associated with tangible reinforcement was related to decreased interpersonal relations or the level of respect and trust among students ($r=-.37$, $p=.05$). No significant correlations were found between school climate and negatively reinforced functions for nonattendance.

Simultaneous multiple regressions revealed that 6 school climate variables did not predict ANA, ESE, and AGB functions for nonattendance. A simultaneous multiple regression analyses revealed parent involvement and sharing of resources predicted attention-seeking (AGB) functions for nonattendance ($F(6, 21) = 3.13$, $p = .02$, adjusted $R^2=.32$).

No significant correlation was found between youth ethnic identity and everyday discrimination. A stepwise multiple regression revealed that the 3 youth ethnic identity variables did not predict everyday discrimination. A stepwise multiple regression was conducted to determine which school climate variables best predicted perceived everyday discrimination. The school building subscale or the overall condition of the school and

materials inside predicted 23.3% of the variance in everyday discrimination ($F(1, 24) = 7.31, p = .01$). No other school climate variables predicted everyday discrimination.

Family conflict and difference in ethnic identity scores were also examined on an exploratory basis. Difference in parent and child ethnic identity did not predict family conflict on the FES scale.

CHAPTER 5

DISCUSSION, CONCLUSIONS, AND RECOMMENDATIONS

The present study involved contextual variables related to school refusal behavior and contained a more representative sample of youth with attendance difficulties than previous studies. Contextual variables included youth and parent ethnic identity, family environment, school climate, and perceptions of daily discrimination. The present study also examined differences between referral sources (community and clinic) on ethnic identity, psychopathology, and functions of school refusal behavior.

The sample in the present study included 154 youth-parent dyads from two community truancy programs (community sample) and 28 youth-parent dyads from a specialized clinic for school refusal behavior (clinic sample). The two samples did not differ on age or gender. As expected, the community sample comprised more youth who identified with an ethnic minority group than the clinic sample. No significant differences were found for youth ethnic identity with respect to gender or age. Youth who identified as belonging to an ethnic minority group, however, did report increased total ethnic identity and identity search compared to youth who identified as part of the ethnic majority group (European American).

Ethnic Identity and Sample Differences

The first overall prediction was explored in three parts and involved level of youth and parent ethnic identity as well as ethnic group classification across the clinic and community samples. Youth ethnic identity variables (total ethnic identity, identity search, and affirmation, belonging, and commitment) were expected to be equivalent across clinic and community samples. Youth in the community sample, however,

reported higher scores of ethnic identity search than the clinic sample and identified their ethnicity as belonging to an ethnic minority group. These setting differences remained stable when ethnicity was controlled. Youth in the community sample that identified their ethnicity as belonging to an ethnic minority group reported higher scores of total ethnic identity and identity search than ethnic minority youth in the clinic sample. There were no differences in ethnic identity scores between the samples for youth that identified their ethnicity as belonging to the ethnic majority group. These results match previous findings that ethnic minority groups are associated with increased absenteeism and dropout rates (Levine, Metzendorf, & VanBoskirk, 1986; National Center for Education Statistics, 2006; Rood, 1989). Ethnic identity is also more salient for ethnic minority groups than ethnic majority groups (Phinney & Alipuria, 1990; Smith, 1991; Turner & Brown, 2007). Ethnic minority groups tend to strengthen their sense of ethnic identity over time, whereas ethnic majority groups tend to display more stable ethnic identity (French, Seidman, Allen & Aber, 2006).

Ethnic identity may be important to address in community settings due to the higher ethnic minority group representation in these settings. Initial intervention services for ethnic minority youth are often conducted within a juvenile justice setting despite the fact that these youth have serious mental health needs (Rawal, Romansky, Jenuwine, & Lyons, 2004). Ethnic minority groups may eschew mental health services they feel are associated with a dominant ethnic group, so incorporating ethnic identity components into juvenile justice setting treatments may be beneficial. In addition, ethnic identity is associated with protective variables such as self-esteem and reduced psychopathology (Costigan et al., 2010; Marie et al., 2008; Phinney & Alipuria, 1996). Ethnic identity is

also related to increased school involvement, engagement, and enrollment (Davalos, Chavez, & Guardiola, 1999; Esparza & Sánchez, 2008; Irving & Hudley, 2008; Shin, Daly, & Vera, 2007).

Parent ethnic identity was also expected to be equivalent across clinic and community samples. Parents in the community sample, however, reported higher scores of total ethnic identity, identity search, and affirmation, belonging, and commitment than parents in the clinic sample. These findings support research that ethnic identity is more salient for ethnic minority than ethnic majority groups (Negy, Shreve, Jensen, & Uddin, 2003). Ethnic identity can provide a sense of belonging to a group, and belonging is associated with enhanced self-esteem, psychological well-being, and self-concept (Phinney et al., 2001).

Professionals who address cases of school refusal behavior should consider these findings. Parents who feel their ethnic identity is respected and understood may be more involved and collaborative in treatments for attendance difficulties. Parent involvement has been associated with increased school attendance (Astone & McLanahan, 1991; Duckworth & DeJong, 1989; Epstein & Sheldon, 2002; McNeal, 1999). Increased parent involvement such as assisting with school work, monitoring a child's peer networks, and participating at school is also associated with enhanced grade point average and credits earned (Falbo et al., 2001). Conversely, lack of parent involvement in school is associated with greater discrimination and institutional barriers for Latino students (Martinez, DeGarmo, & Eddy, 2004).

Youth in the community sample were expected to identify their ethnicity as belonging to an ethnic minority group more than the clinic sample, and this was

confirmed. These findings support research that youth with attendance difficulties vary across referral source with respect to racial characteristics. Youth who enter specialized clinics for school refusal behavior tend to be European American; ethnic minorities are often underrepresented in these settings (Bernstein & Garfinkel, 1986; Bernstein et al., 1997; Hansen et al., 1998; Kearney, 2001). Ethnic minority groups may feel more stigmatized by mental disorders, underutilize mental health services, and prematurely terminate services (Rawal, Romansky, Jenuwine, & Lyons, 2004; Snowden, 1999; Sue, Fujino, Hu, Takeuchi, & Zane, 1991; Sue & Sue, 2003; Varela & Hensley-Maloney, 2009). Researchers contend that some mental health professionals are less culturally sensitive and fail to embrace cultural biases of ethnic minority groups (Guthrie, 1997; Sue & Sue, 2003). Ethnic identity may be a variable that mental health professionals could consider to increase participation and continuation in services.

Ethnic Identity and School Refusal Behavior

The second overall prediction was explored in two parts and involved ethnic identity and school refusal behavior functions as well as related psychopathology. Ethnic identity level was expected to be equivalent across the primary functions for school refusal behavior, and this was confirmed. Ethnic identity may thus be independent of specific function and related more to broader factors associated with absenteeism. For example, ethnic identity is related to higher grade point averages, school enrollment, involvement in extracurricular activities, and school engagement (Costigan et al., 2010; Davalos, Chavez, & Guardiola, 1999; Shin, Daly, & Vera, 2007). Ethnic identity is also related to increased studying and completion of homework and less class skipping (Esparza and Sánchez, 2008).

Youth with greater ethnic identity were expected to have lower scores on self- and parent-reported psychopathology, but results were mixed. Ethnic identity was associated with less cognitive problems and inattention but more generalized anxiety and perfectionism. Ethnic identity search was associated with less depression and psychosomatic complaints but more perfectionism and total anxiety. Affirmation, belonging, and commitment was associated with less cognitive problems and inattention but more generalized anxiety.

The relationship between internalizing symptoms and ethnic identity may relate to comparisons youths make to same-ethnicity peers. Youths compare their personal characteristics to their ethnic group during ethnic identity formation. These comparisons may lead to pressure to conform, concerns about confirming stereotypic behavior of the ethnic group, and exposure to messages of racial socialization or positive and negative messages regarding the ethnic group from family (Chavez & French, 2007). Chavez and colleagues (2007) found that increased pressure to conform, concerns about confirming ethnic group stereotypes, and racial socialization predicted higher anxiety.

Other results were mixed in the present study with respect to ethnic identity and psychopathology associated with school refusal behavior. The relationship of ethnic identity and psychopathology may be complex, with differences in psychopathology perhaps based more on specific patterns of risk and protective factors for psychological disorders for different ethnic groups. Roberts and Roberts (2007) found that stronger ethnic identity and ethnic salience protected against psychopathology for African American but not Mexican American youth. European American ethnic identity was associated with lower risk for anxiety disorders but increased risk for comorbid disorders

(Roberts et al., 2007). Youth from mixed ethnic backgrounds may also be more susceptible to psychopathology and psychosocial stress than youth from one ethnic background (Brown, 2001; Gibbs, 1987; Milan & Keily, 2000; Sue & Sue, 2003). Ethnic identity may thus need to be studied across specific ethnic groups to better understand its unique risk and protective nature (Roberts et al., 2007).

Ethnic Identity and Family Variables

The third overall prediction was explored in two parts and involved ethnic identity and the parent-youth dyad as well as the family environment. Younger youth (age 10-12 years) and parent ethnic identity scores were expected to be equivalent and this was confirmed. Mid-range and older youth (age 13-14 years and 15-16 years) and parent ethnic identity scores were expected not to be equivalent and this was confirmed for total ethnic identity, and affirmation, belonging, and commitment but not for ethnic identity search.

Ethnic identity formation begins in early adolescence and gradually increases toward a plateau in late adolescence (French, Seidman, Allen & Aber, 2006; Pahl & Way, 2006; Phinney, 1989; Phinney & Tarver, 1988). Findings from the present study support this developmental trajectory. Younger youth were more similar to parent ethnic identity level and may be in the initial stages of ethnic identity exploration. Early ethnic identity formation includes learning about history and traditions and examining ethnic group discrimination and prejudice through discussions with family and friends (Phinney, 1989; Phinney et al., 2001).

Ethnic identity evolves during adolescence as youth explore messages about their ethnic identity from peers, school, and the community (Phinney, 1996). Results from the

present study confirm that older youth begin to differentiate from their parents. An individual in this stage generally has positive attitudes towards their ethnic group but may have some variation as well (Phinney, 1996). Such variation may account for different ethnic identity scores between parents and older youth.

Higher scores on the FES intellectual-cultural subscale were expected to be associated with greater youth and parent ethnic identity. The intellectual-cultural subscale measures the extent to which families have political, intellectual, and cultural interests. FES intellectual-cultural scores were not associated with youth ethnic identity scores. Parent total ethnic identity scores, however, predicted the most variance in FES intellectual-cultural scores followed by affirmation, belonging, and commitment, and identity search.

Youth ethnic identity did not predict degree of political, intellectual, and culture activities in the family. Parent total ethnic identity, affirmation, belonging, and commitment, and identity search, however, did predict higher levels of political, intellectual, and culture activities in the family. A child's ethnic identity level may thus be shaped more by the broader family dynamic. Adolescents initially rely on family members to explore their ethnicity and group membership (Phinney et al., 2001). Family members provide a reference for history and traditions, ethnic group discrimination, and prejudice, and heavily influence ethnicity identity formation (Phinney, Ferguson, & Tate, 1997). Community cohesion and promotion of culture also influences adolescents' ethnic identity (Phinney, Romero, Nava, & Huang, 2001). These findings suggest that family components influence ethnic identity less at the individual level and perhaps more at a systemic level.

Community and Clinic Sample Differences

The fourth overall prediction was explored in three parts and involved referral setting (community vs. clinic) and differences in school refusal behavior function and psychopathology related to school refusal behavior. Youth in the community setting were expected to exhibit higher scores on positively reinforced functions for nonattendance and youth in the clinic setting were expected to exhibit higher scores on negatively reinforced functions for nonattendance. Youth in the clinic sample reported higher scores of avoidance of stimuli provoking negative affectivity and escape from aversive social and/or evaluative situations for nonattendance (negative reinforcement) than the community sample, thus partially supporting the prediction. Youth in the clinic sample, however, also reported higher scores of positively reinforced nonattendance than the community sample.

Youth in the clinic sample were also expected to report higher internalizing psychopathology, whereas youth in the community sample were expected to report higher externalizing psychopathology. The clinic sample reported more internalizing (separation anxiety, panic, anxiousness and worry, and psychosomatic complaints) and externalizing symptoms (emotional liability, and general problematic behaviors and hyperactivity) than youth in the community sample.

These results partially support previous findings of differences across referral settings. Higher levels of internalizing symptoms are found in clinic samples and higher levels of externalizing symptoms are found in community samples (Egger et al., 2003; Kearney & Albano, 2004; McShane et al., 2001). Externalizing symptoms are often expressed in conjunction with internalizing symptoms (Kashani, Holcomb, & Orvaschel,

1986). Tantrums, self-harm, and verbal and physical aggression are often used to delay going to school or to get attention in youth with school refusal (Kearney, 2001). Severe symptomatology has been found in youth that refuse school with underlying anxiety and depression (Bernstein, 1999). Symptomatology associated with psychological disorders such as sleep difficulties are reported more in youth with school refusal than youth with truancy (Egger et al., 2003). Youths referred to clinic settings may thus have more severe symptoms and comorbid conditions than youths in community settings.

These differences may reflect that fact that the community sample was referred to a legal and not a mental health system like the clinic sample. Some schools bypass mental health services in favor of legal remedies due to logistical ease and zero tolerance policies for tardiness and unexcused absences (James & Freeze, 2006; Kearney, 2008a; Reid, 2003). Social work and criminal justice researchers have focused less on mental health issues and more on broad contextual factors related to absenteeism such as teenage pregnancy, parenting, family disarray, homelessness, poverty, association with delinquent peers, and at-risk neighborhoods (Bowen & Richman, 2002; Chapman, 2003; Crowder & South, 2003; Henry, 2007; Kearney, 2008a; Peterson, Luze, Eshbaugh, Jeon, & Kantz, 2007). Psychologists who operate specialized clinics, however, emphasize assessment and treatment of psychopathology related to nonattendance. Self- and parent reports of psychopathology may differ across settings because of different assessment emphases in these settings. Settings that incorporate both perspectives may obtain a more accurate picture of nonattendance behaviors and provide more effective treatment.

Ethnic Identity and Exploration of Other Contextual Variables

Exploratory analyses were also conducted to examine school climate and perceived daily discrimination with respect to ethnic identity and function for nonattendance. No significant relationship was found between school climate and ethnic identity. No significant relationship was found between daily discrimination and ethnic identity. School climate regarding the overall condition of the school, however, did predict daily discrimination. Youth who felt that the overall condition of the school and materials in the school were lacking reported increased perceptions of daily discrimination. Youth who feel the school environment is inadequate are less likely to engage in the activities and opportunities a school provide (McNeal, 1999b; Weisman & Gottfredson, 2001). Youth who are not engaged at school tend to have less positive peer supports at school and may thus perceive increased discrimination (Kingery & Erdley, 2007). Peer support is also a protective factor from the negative effects of discrimination (Grossman & Liang, 2008). Parent involvement and student perception that academic activities and opportunities are shared equally among students predicted nonattendance related to attention seeking. No significant relationship was found between school climate and other functions for nonattendance.

School climate refers to student connectedness to a school via academic, social, and other support and can include positive management of the classroom, participation in extracurricular activities, and adequate disciplinary procedures (Kearney, 2008b). Acceptance, value, safety, and respect relate to school climate as well (Brookmeyer, Fanti, & Henrich, 2006; McNeely, Nonnemaker, & Blum, 2002; Shochet, Dadds, Ham, & Montague, 2006). Dissatisfaction with the school environment and perception of

discrimination from peers could affect school attendance. Perception of discrimination has been found to negatively impact academic outcomes such as grade point average and attendance (Benner & Graham, 2011). Youth who decide to leave school also report that rejection by peers, disengagement from the school environment, and conflict with teachers were primary factors (Lessard et al., 2008). Conversely, positive school climate is related to decreased school dropout (Brookmeyer et al., 2006). Engagement and participation in school related activities also relate to less chronic absenteeism (Epstein et al., 2002; South, Haynie, & Bose, 2007).

Clinical Implications

The present study is unique in that it examined the contextual variable of ethnic identity, which has not been explored in a school refusal behavior population. A better understanding of components that influence nonattendance can be achieved by examining such contextual variables at various levels (Kearney, 2008a; Lyon & Cotler, 2009). The following sections cover the clinical implications of the present study with respect to these different levels (i.e., youth, parent, family, peers, school, and community). Clinical implications in these sections involve assessment, treatment, and/or prevention practices.

Youth

Assessment. Findings from the present study suggest the need to integrate ethnic identity components into the assessment process for youth with school refusal behavior. Measures such as the Multigroup Ethnic Identity Measure (MEIM) as well as specific questions during clinical interviews could provide more information about salience and strength of ethnic identity as well as internalizing symptoms associated with ethnic identity formation. Anxiety and other internalizing symptoms that occur in the early

stages of ethnic identity formation may be critical for understanding function of symptoms and appropriate treatment approaches.

Differences between referral settings in the present study suggest that assessment could be tailored to examine relevant contextual variables such as ethnic identity and psychopathology associated with school refusal behavior. The clinic sample was largely European American and ethnic identity was a less integral component, but the community sample was more ethnically diverse and reported higher levels of ethnic identity search. Assessors may want to examine ethnic identity and stage of ethnic identity formation, especially in community programs, to identify risk factors associated with greater nonattendance (Allen & Mitchell, 1998; Chavez & French, 2007; Costello, Compton, Keeler, & Angold, 2003; Ginsburg & Silverman, 1996; Glover, Pumeriega, Holzer, Wise, & Rodriguez, 1999; Gross et al., 2006; McLaughlin, Hilt, Nolen-Hoeksema, 2007; Nguyen, Huang, Arganza, & Liao; 2007; Yao, Solanto, & Wender, 1988).

The clinic sample, however, exhibited more internalizing and externalizing psychopathology than the community sample. A thorough multimodal assessment involving various sources such as parent and teachers is thus recommended to provide a detailed picture of psychopathology related to school refusal behavior as well as function of nonattendance. A functional analysis that identifies primary forms and functions of school refusal behavior from multiple sources has been recommended (Kearney, 1993, 2001, 2007b, 2008a, 2008b; Kearney & Albano, 2004, 2007; Kearney & Silverman, 1990, 1996). Assessors may wish to focus on a child's resistance during the morning routine, difficulties riding the bus and entering school, and problematic behaviors such as

crying, tantrums, noncompliance, and delinquent acts (Kearney, 2001, 2007, 2008; Kearney & Albano, 2007). Assessors could also obtain information from teachers about a youth's classroom behavior such as anxiety, defiance, withdrawal, and disruptive acts. Changes in psychopathology should also be assessed throughout treatment.

Treatment. Youth in the community sample reported higher levels of ethnic identity search and were more ethnically diverse than youth in the clinic sample. Psychoeducation about anxiety and ethnic identity formation may help youth reduce anxiety and successfully navigate the ethnic identity formation process. Risk factors related to ethnic identity formation such as increased psychopathology and anxiety from pressure to conform could also be addressed during therapy. Clinicians could address anxiety via cognitive behavioral techniques such as relaxation training to reduce physiological symptoms of anxiety, cognitive restructuring to address negative self-appraisal related to ethnic identity, and modeling and role-playing to boost social skills if a youth has interpersonal deficits (Albano, Chorpita, & Barlow, 2003; Barrett & Farrell, 2009; King, Heyne, & Ollendick, 2005; Silva, Gallagher, & Minami, 2006).

Youth in the clinic sample exhibited more internalizing and externalizing psychopathology than youth in the community sample. Longer and more intensive treatment may thus be necessary for youths referred to clinic settings. In addition, therapists may need to integrate parents, other family members, and school officials into treatment, especially for chronic cases of absenteeism (Epstein & Sheldon, 2002; Sheldon et al., 2005). Parents are more compliant with treatment when they are included in the treatment development process (Tharinger et al., 2008). Clinicians could boost such compliance by providing psychoeducation regarding the treatment process, exploring

hesitations about treatment, and considering important ethnic variables. Parents could also be encouraged to participate in a contingency management plan to address noncompliance and enhance reentry into school (Elliott, 1999; Kearney & Albano, 2007). A written contract outlining the youth's responsibilities and privileges with input from parents, youth, and therapist may also be helpful for older youth (Kearney & Albano, 2007).

Parents can also be encouraged to restructure parent commands, provide consistent expectations, give directive statements, and respond appropriately to child noncompliance (Kearney, 2001, 2007, 2008; Kearney & Albano, 2007). Communication problems such as interrupting, blaming, ignoring, and silence can also be addressed during this process (Foster & Robin, 1997). Parents must develop consistent morning and evening routines to re-establish appropriate school preparation behaviors (Kearney & Albano, 2007). Parents can also provide opportunities for peer interaction and involvement in extracurricular activities to enhance motivation for school attendance.

Guidance counselors, school-based social workers, and school psychologists could also be incorporated into treatment by implementing a parallel contingency management system at school to reduce noncompliance and increase adaptive behaviors related to school attendance. School personnel could administer anxiety reducing techniques at school, provide an area where a child could become calm when anxious, or help a child address potential obstacles to attendance. Clinicians should ensure that parents and school personnel maintain frequent contact to ensure consistency across settings.

Parent

Assessment. Younger youth and parents were similar but older youth and parents differed with respect to ethnic identity. Such differentiation may increase risk for psychopathology and nonattendance via parent-child conflict. Assessors may thus wish to focus on ethnic identity differences among children and parents. Assessments could focus on parenting style, parent-child communication, and parental psychopathology and ethnic identity. Measures such as the Parental Authority Questionnaire (PAQ) (Buri, 1991) could assess parenting style and communication. Clinical interviews and behavioral observations with a youth and parent could provide additional information about variables such as controlling parenting styles, attachment difficulties, and parental anxiety (Tharinger et al., 2008).

Parents in the community sample had elevated ethnic identity scores. Assessors in community based programs may thus wish to integrate measures such as the MEIM. Such integration may lead to better rapport with parents and thus a more accurate assessment of nonattendance. Ethnic minority groups may associate a stigma to mental health services (Sue & Sue, 2003; Varela & Hensley-Maloney, 2009). Parents may feel more comfortable addressing relevant contextual variables such as cultural beliefs, important traditions and components relevant to culture, and problematic family dynamics that affect attendance. Assessors should also explore the role of the youth in the family as well as educational obstacles that are culturally related. Some families may believe that the role of the male is to provide for the family (Sue & Sue, 2003), so school may be viewed as a secondary task. Language barriers are also associated with lack of parental involvement in school and can contribute to a child's educational difficulties

(Gersten & Baker, 2000; Sue & Sue, 2003). American Indian and Alaskan native youth often drop out of school, which may relate to a cultural emphasis on contribution to community, obstacles such as poor family, school, and community support, and alcohol use and domestic violence (Juntunen et al., 2001; Sue & Sue, 2003).

Treatment. Psychoeducation about ethnic identity formation as well as parenting strategies that foster support of a youth while allowing differentiation and autonomy could be a focus of treatment. Parents should also be actively involved in their child's treatment and school-related events to ease this differentiation process. Indeed, parent involvement and support is related to positive influence on ethnic identity formation (Phinney, Romero, Nava, & Huang, 2001). Such involvement may need to be more nuanced as a child ages, however, and becomes more autonomous from his family (Phinney, 1989; Phinney et al., 2001).

Professionals who address truancy in community settings should be particularly sensitive to parent ethnic identity. Parents may be integrated into intervention at the school more successfully if professionals understand how parent ethnic identity affects parenting strategies and beliefs about school attendance. Parents may then feel more connected and thus more enthusiastic about their child's treatment (Tharinger et al., 2008). Treatment length and intensity could also be reduced by incorporating parents into school-based interventions and enhancing parental supervision of a child (Kearney & Albano, 2007).

Family

Assessment. Older youth and parents reported different levels of ethnic identity in the present study. Information regarding family dynamic variables such as cohesion,

enmeshment, and control may also be highly relevant. Some families of youth who refuse school also exhibit excessive dependency, detachment, and isolation (Kearney, 2001; McShane, Walter, & Rey, 2004; Waldron, Shrier, Stone, & Tobin, 1975). Marital and communication problems are associated with school refusal behavior as well (McShane et al., 2001; Timberlake, 1984). Problematic ethnic identity formation could affect these dysfunctional family patterns and should thus be evaluated closely. Family-based assessment strategies may be useful in this regard and include self-report measures such as the Family Environment Scale (FES), behavioral observations of the child within the family context, and role plays to evaluate family interaction patterns and potential intervention targets (Tharinger et al., 2008).

The elevated degree of psychopathology found among youths in the present study also indicate that family members are needed to provide an accurate picture of attendance-related behaviors such as anxiety, worry, or externalizing problems. An assessment that includes most family members would also help professionals more accurately determine function of nonattendance, relevant contextual variables such as consistency of behaviors among different family members and different settings, and differences between child and family ratings of behavior (Elliott, 1999; Kearney & Albano, 2007; Tharinger et al., 2008). Family members could complete daily ratings of a youth's anxiety, depression, distress, noncompliance, and disruption. Number of full or partial days missed as well as problematic behaviors that occur before, during, or after school could also be monitored by family members.

Treatment. Findings from the present study indicate that ethnic differentiation from the family and among family members may result in increased internalization and

subsequent discord that may need to be addressed in treatment. Protective factors associated with ethnic identity, such as increased psychological well-being (Abu-Rayya, 2006; Marie et al., 2008), belongingness, and self-esteem (Costigan et al., 2010; Phinney et al., 2001), could also be emphasized in family treatment. A combination of CBT and family interventions is effective for reducing child anxiety (Elliott, 1999; Epstein et al., 2002; Ginsburg, Silverman, & Kurtines, 1995; Northey, Wells, Silverman, & Bailey, 1993; Silverman, Kurtines, Jaccard, & Pina, 2009). Such an approach is also successful for treating anxiety-based nonattendance (Dadds et al., 1999). These treatments focus on exposures, anxiety management, family support, and effective parenting strategies. Psychoeducation about ethnic identity could be integrated into these programs so parents could help youth manage internalizing symptoms regarding ethnic identity. Treatment could also focus on exploring youth differentiation regarding ethnic identity as well as discord among family members by fostering appropriate and effective communication among family members.

Psychopathology related to school refusal behavior may also be reduced by integrating family members into treatment. This is especially critical for more severe nonattendance problems and perhaps for youth referred to clinic settings. A behavioral family therapy approach that focuses on problem-solving and positive communication during family interactions could help reduce discord and other dysfunctional dynamics (Kearney, 2001). Consistent contingency management may be useful to address tantrums, noncompliance, and physiological symptoms related to anxiety (Kearney & Silverman, 1995). Family members could monitor attendance, provide consistent structure and consequences for nonattendance, and escort a youth to school and classes

(Kearney, 2007a). More severe nonattendance difficulties may need to be addressed via home-based treatment to provide family members with extra assistance. A collaborative effort among family members to consistently implement these treatment strategies could reduce future slips and relapses regarding nonattendance (Kearney & Silverman, 1995).

Peers, School, and Community

Ethnic identity findings from the present study may also have implications for absenteeism prevention programs that involve more complex levels such as peers, school, and community. Findings from the present study suggest that ethnic identity was a salient component for youth and parents referred to community-based prevention programs. Some examples are presented here.

The School Transitional Environment Project (STEP) (Felner et al., 1993) is a preventive program to help youth develop a positive relationship with the homeroom teacher, especially during transitional periods in middle and high school. Teachers consult with parents to discuss barriers to attendance and provide support to students. This program was implemented in high-risk urban schools with ethnic diversity similar to the present study.

A program like STEP could incorporate ethnic identity by scheduling cultural events at the school and providing resources in the classroom to explore cultural history and traditions. The STEP program provides a supportive environment with peers and teachers that could allow a youth to feel a sense of belonging and safety when navigating the ethnic identity formation process at school. Other prevention programs have also found that peer (Baker, 2000) and teacher mentors (DeSocio et al., 2007) help increase attendance and school climate. Social skills development and positive interpersonal

interactions with peers of similar ethnic identity could also be incorporated into STEP to enhance adaptive exploration of ethnic identity (Phinney et al., 2001; Phinney, Ferguson, & Tate, 1997) and to increase attendance (Astor, Meyer, Benbenishty, Marachi, & Rosemond, 2005; Lessard et al., 2008; Mytton, DiGuseppi, Gough, Taylor, & Logan, 2002; Woody, 2001).

The Truancy Project in Atlanta pairs youth with volunteer lawyers who serve as mentors (Gullatt et al., 1997). Youth report that preventive community programs such as the Truancy Project provide a sense of belonging and safety from the violence and crime of their neighborhood (Rodriquez et al., 2009). Disorganized and unsafe neighborhoods (Chapman, 2003; Crowder & South, 2003; Henry, 2007) as well as disengagement with the school environment (Lessard et al., 2008; South, Haynie, & Bose, 2007; Weisman & Gottfredson, 2001) are risk factors for nonattendance. The Truancy Project could be enhanced by helping youth explore positive and negative messages in the neighborhood about their ethnic identity. This exploration process could be enriched by using same ethnicity mentors who can also provide academic and other assistance. Youth generally prefer same-ethnicity mentor relationships and these relationships do enhance ethnic identity (González-Figueroa & Young, 2005; Kaplan, Turner, Piotrkowski, & Silber, 2009; Kim, Goto, Bai, Kim, & Wong, 2001).

Communities in School (CIS) is a nonprofit organization that targets high-risk school districts that are prone to dropout (Communities in School, 2011). The organization provides (1) a community mentor to the youth, (2) a safe place for the youth, (3) basic necessities such as food, shelter, and healthcare, (4) skills training in the form of

tutoring, career planning, literacy programs, employment training, and job shadowing, and (5) youth service through peer mentoring and volunteering.

Ethnic identity could be incorporated into the CIS support areas. High risk-schools tend to have higher percentages of ethnic minority students, so ethnic identity may be a salient variable. Youth could explore their ethnicity with a positive role model in the community mentorship aspect of CIS. Community mentors could provide opportunities to explore ethnicity by conveying personal experiences and sharing cultural activities in the community. Youth who serve as same-ethnicity peer mentors later in the program could also function as positive models. Positive peer relationships are associated with ethnic identity formation (Shin, Daly, & Vera, 2007) and reduced psychopathology (Costigan, Korysma, Hua, & Chance, 2010).

Limitations

Several limitations were evident in the present study. First, a clinic sample that better matched the size of the community sample would have allowed for more sophisticated comparisons and analyses. Second, the clinic sample was limited in ethnic diversity and several ethnic groups (Asian American, African American, and Native American) were minimally represented in both samples. A more diverse sample would have allowed for a greater understanding of ethnic identity formation across ethnic groups as well as exploration of within ethnic group differences. Lack of sample diversity limited the generalizability of the results.

Third, the present study involved youth self-report and parent report only. Reports from various sources such as teachers, other family members, probation officers, and peers would have provided a more thorough understanding of psychopathology and

contextual variables. Greater insight into systemic family components that influence ethnic identity formation would also have been facilitated by reports from multiple family members rather than only one parent.

Fourth, ethnic identity would have been better assessed using methods in addition to self-report. Structured interviews and behavioral observations may provide a more accurate picture of influential contextual variables. Youth and parent journaling of behaviors associated with nonattendance may also provide a more accurate picture of behaviors than self-report based on memory. Detailed daily logs that allow parents and youth to monitor and rate attendance and psychopathology could be used (Kearney & Albano, 2007). A more accurate assessment of nonattendance based on percentage of days missed would have been beneficial.

Recommendations for Future Study

The present study provides important implications for future research. The first recommendation is that researchers should work to understand the protective and risk factors associated with ethnic identity formation. The present study found mixed results in this regard, suggesting the need for a more thorough examination of contextual variables that influence youth ethnic identity formation (Kearney, 2008a; Lyon & Cotler, 2009). Researchers may wish to broaden the scope of their work in this area by examining more systemic levels such as family, school, and community (Kearney 2003, 2008a, 2008b; Lyon & Cotler, 2009).

Researchers may also wish to examine more detailed family interaction variables vis-a-vis ethnic identity formation. Self-report measures on parenting style as well as behavioral observations of parent-child interactions may be a better measure of parent-

child dynamics and general family functioning. Researchers may be able to better understand parenting components such as structure, autonomy, and control that foster or hinder ethnic identity formation by examining authoritarian, authoritative, passive, and uninvolved parenting styles. Researchers should also explore maladaptive dynamics such as enmeshment and conflict to better understand the familial relationship with ethnic identity formation. Tasks or activities that involve family member interactions may allow for rich and more accurate data about family dynamics than self-report (Tharinger et al., 2008).

Researchers may also wish to examine ethnic identity at more complex levels such as peer, school, and the community. Youth explore their ethnic identity with family and friends and within societal structures such as school and neighborhoods (Phinney 1989; Phinney et al., 2001; Phinney, Ferguson, & Tate, 1997). Social skills, type and amount of friendships, and participation in extracurricular activities are peer variables that could be explored in relation to ethnic identity formation. Diversity of teaching staff, promotion of cultural diversity, ethnic composition of the student body, and opportunities to explore ethnic identity at school may also affect ethnic identity formation via discrimination, conformity, and promotion of culture in the school environment. Lastly, ethnic composition of the neighborhoods surrounding a school may provide a better understanding of discrimination as well as negative and positive messages about majority and minority ethnic groups to which youth are exposed.

More information about the risk and protective nature of ethnic identity could be obtained by examining stage of ethnic identity in addition to strength of ethnic identity. An individual's relationship with one's own ethnic group as well as other ethnic groups

changes depending on stage of ethnic identity formation (Phinney, 1996). A more specific understanding of the transition from internalizing symptoms at early stages to secure attachment at later stages is needed.

Researchers should also explore differences in contextual variables such as youth personality traits, length and amount of time missed from school, and psychopathology differences between referral settings. The present study confirmed that differences in psychopathology exist across settings and results have been mixed in the literature (Egger et al., 2003; Kearney & Albano, 2004; Kennedy, 1965; McShane et al., 2001). Treatment strategies in these settings may have to be adapted to account for differences in contextual variables such as ethnic identity. Overall, the present study provides further support for developing a systemic understanding of school refusal behavior. The present study highlights the importance of addressing ethnic identity from multiple levels such as the youth, parent, and family. The present study also highlights differences that exist between referral settings for school refusal behavior. These differences may be reduced, however, by considering relevant contextual variables such as ethnic identity. The present study also complements the growing body of literature supporting examination of school refusal behavior based on function and contextual variables.

Table 1

Studies Presenting Comorbid Psychiatric Conditions with School Absenteeism

Study	Type of Sample	Internalizing Disorders	Externalizing Disorders	
Kearney & Albano (2004)	Clinic (n=143)	SAD (22.4%)	ODD (8.4%)	
		GAD (10.5%)	CD (2.8%)	
		Major Depression (4.9%)	ADHD (1.4%)	
		Specific Phobia (4.2%)	Enuresis (0.7%)	
		Social Anxiety (3.5%)		
		Panic Disorder (0.7%)		
		PTSD (0.7%)		
Egger, Costello, & Angold (2003)	Community Truants (n=517)	Depression (7.5%)	CD (14.8%)	
		GAD (0.6%)	ODD (9.7%)	
		SAD (0.3%)	Substance (4.9%)	
		Simple Phobia (0.2%)	ADHD (0.5%)	
		Social Phobia (0.2%)		
			Panic (0.2%)	
	Anxious School Refusal (n=165)	Depression (13.9%)	ODD (5.6%)	
		SAD (10.8%)	CD (5.0%)	
		Social Phobia (3.2%)	ADHD (1.3%)	
		GAD (2.2%)		
Simple Phobia (2.1%)				
		Panic (0.3%)		
Mcshane, Walter & Ray (2001)	Clinic Inpatient (n=93)	Mood disorders (30%)	ODD (14%)	
		SAD (13%)	ADHD (3%)	
		GAD (6%)	CD (0.5%)	
		Anxiety Disorder NOS (4.5%)	Substance (2%)	
		Adjustment Disorder (3%)	Disruptive Behavior Disorder NOS (1%)	
		Social Phobia (3%)		
		Agoraphobia (0.5%)		

	Mood Disorders (15%)	
	SAD (5%)	ODD (5%)
Outpatient	Anxiety Disorder NOS (3%)	Disruptive Behavior
(n=58)	GAD (2%)	Disorder NOS (3.5%)
	Panic Disorder (3%)	ADHD (2%)
	Adjustment Disorder (1.5%)	CD (1%)
	Social Phobia (1%)	Substance (0.5%)

Note. CD=conduct disorder; GAD=generalized anxiety disorder; ODD=oppositional defiant disorder; SAD=separation anxiety disorder; Substance= substance abuse; Mood disorders=major depression and dysthymia; PTSD=post-traumatic stress disorder; NOS= not otherwise specified.

Table 2

Proximal and Distal Factors Related to Problematic Absenteeism

Proximal and Distal Factors Related to Problematic Absenteeism	
Child Factors	<ul style="list-style-type: none"> Extensive work hours outside of school Externalizing symptoms/psychopathology Grade retention History of absenteeism Internalizing symptoms/psychopathology Learning-based reinforcers of absenteeism/functions Low self-esteem and school commitment Personality traits and attributional styles Poor health or academic proficiency Pregnancy Problematic relationships with authority figures Race and Age Trauma Underdeveloped social and academic skills
Parent Factors	<ul style="list-style-type: none"> Inadequate parenting skills Low expectations of school performance/attendance Maltreatment Problematic parenting styles (permissive, authoritarian) Poor communication with school officials Poor involvement and supervision Psychopathology School dropout in parents and among relatives School withdrawal Single parent
Family Factors	<ul style="list-style-type: none"> Enmeshment Ethnic differences from school personnel Homelessness Intense conflict and chaos Large family size Poor access to educational aids Poor cohesion and expressiveness Poverty Resistance to acculturation Stressful family transitions (divorces, illness, unemployment, moving) Transportation problems

Peer Factors	<ul style="list-style-type: none"> Participation in gangs and gang-related activity Poor participation in extracurricular activities Pressure to conform to group demands for absenteeism or other delinquent acts Proximity to deviant peers Support for alluring activities outside of school such as drug use Victimization from bullies or otherwise
School Factors	<ul style="list-style-type: none"> Dangerous/poor school climate Frequent teacher absences High systematic levels of grade retention Highly punitive or legal means to address all case of problematic absenteeism Inadequate, irrelevant, or tedious curricula Inadequate praise for student achievement and attendance Inadequate responsiveness to diversity issues Inconsistent or minimal consequences for absenteeism Poor monitoring of attendance Poor student-teacher relationships School-based racism and discrimination
Community Factors	<ul style="list-style-type: none"> Disorganized/unsafe neighborhood Economic pull factors (e.g., plentiful, well-paying jobs requiring little formal education) Geographical cultural and subcultural values High gang-related activity Intense interracial tension Lack of social and educational support services School district polices and legal statutes regarding absences

Note. From Kearney (2008a). An interdisciplinary model of school absenteeism in youth to inform professional practice and public policy. *Educational Psychology Review*, 20, 257-282.

Table 3

Community and Clinic Characteristics

Characteristic	Clinic (N=28)	Community (N=154)
Age (years)	12.5 (1.8)	13.1 (1.2)
Gender (%)	60.7 male	50.6 male
Mom graduated from HS (%)	85.2	52.8
Dad graduated from HS (%)	69.2	41.3
Marital Status (%)		
Married	51.9	37.7
Never Married	7.4	21.2
Separated	22.2	20.5
Divorced	18.5	20.5
Total Siblings (%)		
None	14.8	4.8
1-2	55.5	44.1
3-4	25.9	34.5
5 or more	3.7	16.6
Race (%)		
Asian	0.0	1.3
African American	0.0	9.2
European American	67.9	10.5
Hispanic	21.4	68.4
Multiracial/Biracial	7.1	5.3
Native American	0.0	0.7
Other	3.6	4.6

Note. For age, mean years are listed first by standard deviation in parentheses.

Table 4

Community and Clinic Sample Differences in Ethnic Identity

Ethnic Identity	Community	Clinic	df	<i>t</i>	<i>p</i>
	Mean (SD)	Mean (SD)			
Youth Ethnic Identity	2.82 (.49)	2.59 (.54)	171	2.12	.04
Youth Identity Search	2.51 (.55)	2.14 (.70)	171	2.96	.003
Youth Affirmation, Belonging, Commitment	3.04 (.60)	2.91 (.60)	171	.97	.34
Parent Ethnic Identity	2.99 (.67)	2.48 (.57)	148	3.42	.001
Parent Identity Search	2.61 (.77)	1.97 (.55)	39.1	4.76	< .001
Parent Affirmation, Belonging, Commitment	3.26 (.72)	2.86 (.67)	148	2.48	.01

Note. A significance level of .02 was used to evaluate all results to control for Type I error.

Table 5

Stepwise Multiple Regression Analysis with Youth Ethnic Identity and Internalizing and Externalizing Psychopathology

Predictor	B	S.E.	β	R ²	ΔR^2
Total Ethnic Identity					
Model 1				.041*	.034
Cognitive Problems/Inattention	-.009	.004	-.202		
Model 2				.086**	.072
Cognitive Problems/Inattention	-.010	.004	-.231		
Generalized Anxiety	.010	.004	.213		
Model 3				.122**	.102
Cognitive Problems/Inattention	-.013	.004	-.306		
Generalized Anxiety	.010	.004	.219		
Perfectionism	.011	.005	.205		
Ethnic Identity Search					
Model 1				.037*	.030
Perfectionism	.012	.005	.193		
Model 2				.073**	.059
Perfectionism	.016	.006	.266		
Cognitive Problems/Inattention	-.010	.004	-.204		
Model 3				.109**	.088
Perfectionism	.017	.005	.273		
Cognitive Problems/Inattention	-.012	.004	-.23		
Generalized Anxiety	.010	.004	.191		
Model 4				.144**	.118
Perfectionism	.018	.005	.299		
Cognitive Problems/Inattention	-.010	.004	-.200		
Generalized Anxiety	.016	.005	.310		
Depression	-.010	.004	-.230		
Model 5				.171**	.138
Perfectionism	.018	.005	.291		
Cognitive Problems/Inattention	-.010	.004	-.200		
Generalized Anxiety	.005	.007	.103		
Depression	-.014	.005	-.335		
Total Anxiety	.016	.008	.323		
Model 6				.167**	.141
Perfectionism	.017	.005	.284		
Cognitive Problems/Inattention	-.010	.004	-.199		
Depression	-.015	.005	-.336		
Total Anxiety	.020	.005	.409		

Model 7				.193**	.162
Perfectionism	.019	.005	.312		
Cognitive Problems/Inattention	-.006	.005	-.112		
Depression	-.015	.005	-.338		
Total Anxiety	.023	.006	.471		
Psychosomatic	-.007	.004	-.205		
Model 8				.185**	.159
Perfectionism	.018	.005	.290		
Depression	-.015	.005	-.354		
Total Anxiety	.024	.006	.484		
Psychosomatic	-.009	.003	-.257		
Affirmation, Belonging, & Commitment					
Model 1				.047**	.040
Cognitive Problems/Inattention	-.011	.004	-.218		
Model 2				.078**	.063
Cognitive Problems/Inattention	-.012	.004	-.241		
Generalized Anxiety	.009	.005	.175		

Note. * $p \leq .05$, ** $p \leq .01$

Table 6

Differences Between Youth Ethnic Identity and Parent Ethnic Identity by Age

Ethnic Identity	Youth	Parent	df	<i>t</i>	<i>p</i>
	Mean (SD)	Mean (SD)			
Youth Age 10-12					
Total Ethnic Identity	2.81 (.52)	2.77 (.78)	45	.30	.76
Identity Search	2.48 (.63)	2.37 (.80)	45	.74	.46
Affirmation, Belonging, Commitment	3.05 (.58)	3.06 (.85)	45	-.07	.94
Youth Age 13-14					
Total Ethnic Identity	2.76 (.46)	2.99 (.63)	74	-2.84	.006
Identity Search	2.44 (.54)	2.61 (.76)	74	-1.81	.07
Affirmation, Belonging, Commitment	2.99 (.57)	3.27 (.67)	74	-2.90	.005
Youth Age 15-16					
Total Ethnic Identity	2.66 (.64)	2.97 (.58)	23	-2.27	.03
Identity Search	2.23 (.65)	2.48 (.75)	23	-1.68	.11
Affirmation, Belonging, Commitment	2.98 (.73)	3.32 (.59)	23	-2.24	.04

Table 7

Regression Analysis with Ethnic Identity Variables Predicting FES Intellectual-Cultural Scores

Predictor	B	S.E.	β	<i>t</i>	<i>p</i>
Youth Total Ethnic Identity	61.72	52.21	3.06	1.18	.24
Youth Ethnic Identity Search	-27.32	22.28	-1.58	-1.23	.22
Youth Affirmation, Belonging, & Commitment	-35.92	30.32	-2.11	-1.18	.24
Parent Total Ethnic Identity	114.57	48.24	7.65	2.38	.02
Parent Ethnic Identity Search	-45.81	20.43	-3.49	-2.24	.03
Parent Affirmation, Belonging & Commitment	-67.66	27.83	-4.83	-2.43	.02

Table 8

Community and Clinic Sample Differences in School Refusal Function

School Refusal Function	Community	Clinic	df	<i>t</i>	<i>p</i>
	Mean (SD)	Mean (SD)			
ANA	1.31 (1.11)	3.64 (1.16)	179	-10.00	< .001
ESE	1.00 (.86)	2.09 (1.25)	30.5	-4.36	< .001
AGB	1.74 (1.18)	3.53 (1.41)	179	-7.04	< .001
PTR	2.39 (.98)	2.28 (.92)	179	-.54	.59

Note. ANA = avoidance of stimuli provoking negative affectivity, ESE = escape from aversive social and/or evaluative situations, AGB = attention seeking, and PTR = tangible reinforcement. A significance level of .01 was used to evaluate all results to control for Type I error.

Table 9

Community and Clinic Sample Differences in RCADS T-Scores

Subscale	Community	Clinic	df	<i>t</i>	<i>p</i>
	Mean (SD)	Mean (SD)			
Separation Anxiety	50.79 (10.68)	61.86 (16.61)	23.6	-3.04	.006
Generalized Anxiety	43.80 (10.97)	46.64 (11.95)	169	-1.12	.26
Panic	50.58 (12.28)	58.50 (13.01)	169	-2.80	.006
Social Phobia	41.74 (10.40)	45.09 (11.70)	169	-1.39	.17
Obsession/ Compulsions	45.59 (10.44)	47.64 (9.96)	169	-.86	.39
Depression	48.83 (13.24)	56.18 (14.19)	169	-2.41	.02
Total Anxiety	44.75 (11.43)	51.59 (13.50)	169	-2.56	.01
Total Anxiety & Depression	45.31 (11.98)	52.82 (13.82)	169	-2.69	.008

Note. Means represent T scores. A significance level of .006 was used to evaluate all results to control for Type I error.

Table 10

Community and Clinic Sample Differences in Parent Report of Youth Psychopathology

Subscale	Community	Clinic	df	<i>t</i>	<i>p</i>
	Mean (SD)	Mean (SD)			
Oppositional	61.15 (14.38)	66.05 (12.73)	137	-1.46	.15
Cognitive Problems/Inattention	59.93 (11.83)	67.67 (9.22)	137	-2.84	.005
Hyperactivity	64.93 (16.83)	61.24 (16.06)	137	.93	.35
Anxious-Shy	57.52 (13.57)	69.38 (14.04)	137	-3.67	<.001
Perfectionism	53.14 (9.69)	47.24 (7.67)	137	2.65	.009
Social Problems	58.25 (13.52)	65.05 (14.61)	137	-2.10	.04
Psychosomatic	60.38 (15.34)	80.38 (12.08)	32.7	-6.69	<.001
Conners' ADHD Index	60.69 (13.41)	68.19 (10.06)	137	-2.44	.02
Conners' Global Index: Restless-Impulsive	62.31 (14.39)	67.71 (12.40)	137	-1.62	.11
Conners' Global Index: Emotional Lability	56.82 (14.70)	70.62 (11.18)	33.6	-4.95	<.001
Conners' Global Index: Total	62.02 (15.25)	70.43 (9.79)	39.7	-3.29	.002
DSM-IV: Inattentive	60.25 (13.83)	67.00 (10.99)	137	-2.12	.04
DSM-IV: Hyperactive-Impulsive	63.89 (15.35)	61.10 (14.43)	137	.78	.44
DSM-IV: Total ADHD Combined Type	63.77 (15.10)	66.38 (11.72)	137	-.75	.45

Note. Means represent T scores. A significance level of .004 was used to evaluate all results to control for Type I error.

APPENDIX A

Demographics

1. Child's Age: _____

2. Child's Gender (circle one) M F

3. Child's Ethnicity: (circle one)

Asian African-American European-American

Hispanic Multiracial/biracial Native American

Other _____

4. Did Mother/Guardian graduate from High School? Yes No

5. Did Father/Guardian graduate from High School? Yes No

6. Age (in years and gender of all siblings:

Age: _____ gender: M F Age: _____ gender: M F

Age: _____ gender: M F Age: _____ gender: M F

Age: _____ gender: M F Age: _____ gender: M F

7. Marital status of parents/guardians currently? (circle one)

Married never married separated divorced

APPENDIX B
Family Environment Scale

There are 90 statements. They are statements about families. You are to decide which of these statements are true of your family and which are false. If you think the statement is *True* or mostly *True* of your family, make an X in the box labeled true. If you think the statement is *False* or mostly *False* of your family, make and X in the box labeled false.

You may feel that some of the statements are true for some family members and false for others. Mark True if the statement is true for most members. Mark False if the statement is false for most family members. If the members are evenly divided, decide what is the stronger overall impression and answer accordingly.

Remember, we would like to know what your family seems like to you. So *do not* try to figure out how other members see your family, but *do* give us your general impression of your family for each statement.

- | | | |
|--|-------------------------------|--------------------------------|
| 1. Family members really help and support one another. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 2. Family members often keep their feelings to themselves. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 3. We fight a lot in our family. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 4. We don't do things on our own very often in our family. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 5. We feel it is important to be best as whatever you do. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 6. We often talk about political and social problems. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 7. We spend most weekends and evenings at home. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 8. Family members attend church, synagogue, or Sunday school fairly often. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 9. Activities in our family are pretty carefully planned. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 10. Family members are rarely ordered around. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 11. We often seem to be killing time at home. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 12. We say anything we want to around home. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 13. Family members rarely become openly angry. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 14. In our family, we are strongly encouraged to be independent. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 15. Getting ahead in life is very important in our family. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 16. We rarely go to lectures, plays or concerts. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 17. Friends often come over for dinner or to visit. | <input type="checkbox"/> True | <input type="checkbox"/> False |
| 18. We don't say prayers in our family. | <input type="checkbox"/> True | <input type="checkbox"/> False |

19. We are generally very neat and orderly. True False
20. There are very few rules to follow in our family. True False
21. We put a lot of energy into what we do at home. True False
22. It's hard to "blow off steam" at home without upsetting somebody. True False
23. Family members sometimes get so angry they throw things. True False
24. We think things out for ourselves in our family. True False
25. How much money a person makes is not very important to us. True False
26. Learning about new and different things is very important in our family. True False
27. Nobody in our family is active in sports, Little League, bowling, etc. True False
28. We often talk about the religious meaning of Christmas, Passover, or other holidays. True False
29. It's often hard to find things when you need them in our household. True False
30. There is one family member who makes most of the decisions. True False
31. There is a feeling of togetherness in our family. True False
32. We tell each other about our personal problems. True False
33. Family members hardly ever lose their tempers. True False
34. We come and go as we want to in our family. True False
35. We believe in competition and "may the best man win." True False
36. We are not that interested in cultural activities. True False
37. We often go to movies, sports events, camping, etc. True False
38. We don't believe in heaven or hell. True False
39. Being on time is very important in our family. True False
40. There are set ways of doing things at home. True False
41. We rarely volunteer when something has to be done at home. True False
42. If we feel like doing something on the spur of the moment we often just pick up and go. True False
43. Family members often criticize each other. True False
44. There is very little privacy in our family. True False

45. We always strive to do things just a little better the next time. True False
46. We rarely have intellectual discussions. True False
47. Everyone in our family has a hobby or two. True False
48. Family members have strict ideas about what is right and wrong. True False
49. People change their minds often in our family. True False
50. There is a strong emphasis on following rules in our family. True False
51. Family members really back each other up. True False
52. Someone usually gets upset if you complain in our family. True False
53. Family members sometimes hit each other. True False
54. Family members almost always rely on themselves when a problem comes up. True False
55. Family members rarely worry about job promotions, school grades, etc. True False
56. Someone in our family plays a musical instrument. True False
57. Family members are not very involved in recreational activities outside work and school. True False
58. We believe there are some things you just have to take on faith. True False
59. Family members make sure their rooms are neat. True False
60. Everyone has an equal say in family decisions. True False
61. There is very little group spirit in our family. True False
62. Money and paying bills is openly talked about in our family. True False
63. If there's a disagreement in our family, we try hard to smooth things over and keep the peace. True False
64. Family members strongly encourage each other to stand up for their rights. True False
65. In our family, we don't try that hard to succeed. True False
66. Family members often go to the library. True False
67. Family members sometimes attend courses or take lessons for some hobby or interest (outside of school). True False

68. In our family each person has different ideas about what is right and wrong. True False
69. Each person's duties are clearly defined in our family. True False
70. We can do whatever we want to in our family. True False
71. We really get along well with each other. True False
72. We are usually careful about what we say to each other. True False
73. Family members often try to one-up or out-do each other. True False
74. It's hard to be by yourself without hurting someone's feelings in our household. True False
75. "Work before play" is the rule in our family. True False
76. Watching T.V. is more important than reading in our family. True False
77. Family members go out a lot. True False
78. The Bible is a very important book in our home. True False
79. Money is not handled very carefully in our family. True False
80. Rules are pretty inflexible in our household. True False
81. There is plenty of time and attention for everyone in our family. True False
82. There are a lot of spontaneous discussions in our family. True False
83. In our family, we believe you don't ever get anywhere by raising your voice. True False
84. We are not really encouraged to speak up for ourselves in our family. True False
85. Family members are often compared with others as to how well they are doing at work or school. True False
86. Family members really like music, art and literature. True False
87. Our main form of entertainment is watching T.V. or listening to the radio. True False
88. Family members believe that if you sin you will be punished. True False
89. Dishes are usually done immediately after eating. True False
90. You can't get away with much in our family. True False

APPENDIX C
School Refusal Assessment Scale-Parent-Revised

1. How often does your child have bad feelings about going to school because he/she is afraid of something related to school (for example, tests, school bus, teacher, fire alarm)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

2. How often does your child stay away from school because it is hard for him/her to speak with the other kids at school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

3. How often does your child feel he/she would rather be home with you or your spouse than go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

4. When your child is not in school during the week (Monday to Friday), how often does he/she leave the house and do something fun?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

5. How often does your child stay away from school because he/she will feel sad or depressed if he/she goes to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

6. How often does your child stay away from school because he/she feels embarrassed in front of other people at school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

7. How often does your child think about you or your spouse or family when in school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

8. When your child is not in school during the week (Monday to Friday), how often does he/she talk to or see other people (other than your family)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

9. How often does your child feel worse at school (for example, scared, nervous, or sad) compared to how he/she feels at home with friends?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

10. How often does your child stay away from school because he/she does not have many friends there?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

11. How much would your child rather be with his/her family than go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

12. When your child is not in school during the week (Monday to Friday), how much does he/she enjoy doing different things (for example, being with friends, going places)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

13. How often does your child have bad feelings about school (for example, scared, nervous, or sad) when he/she thinks about school on Saturday and Sunday?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

14. How often does your child stay away from certain places in school (e.g., hallways, places where certain groups of people are) where he/she would have to talk to someone?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

15. How much would your child rather be taught by you or your spouse at home than by his/her teacher at school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

16. How often does your child refuse to go to school because he/she wants to have fun outside of school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

17. If your child had less bad feelings (for example, scared, nervous, sad) about school, would it be easier for him/her to go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

18. If it were easier for your child to make new friends, would it be easier for him/her to go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

19. Would it be easier for your child to go to school if you or your spouse went with him/her?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

20. Would it be easier for your child to go to school if he/she could do more things he/she liked to do after school hours (for example, being with friends)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

21. How much more does your child have bad feelings about school (for example, scared, nervous, or sad) compared to other kids his/her age?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

22. How often does your child stay away from people at school compared to other kids his/her age?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

23. Would your child like to be home with you or your spouse more than other kids his/her age would?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

24. Would your child rather be doing fun things outside of school more than most kids his/her age?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

APPENDIX D
Everyday Discrimination Scale

In your day-to-day life, how often have any of the following things happened to you?

1. You are treated with less courtesy than other people?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

2. You are treated with less respect than other people?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

3. You receive poorer service than other people at restaurants or stores?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

4. People act as if they think you are not smart?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

5. People act as if they are afraid of you?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

6. People act as if they think you are dishonest?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

7. People act as if they are better than you are?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

8. You are called names or insulted?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

9. You are threatened or harassed?

1	2	3	4	5
Never	Hardly Ever	Not too often	Fairly often	Very Often

APPENDIX E
Revised Child Anxiety and Depression Scale

1. I worry about things	Never	Sometimes	Often	Always
2. I feel sad or empty	Never	Sometimes	Often	Always
3. When I have a problem, I get a funny feeling in my stomach	Never	Sometimes	Often	Always
4. I worry when I think I have done poorly at something	Never	Sometimes	Often	Always
5. I would feel afraid of being on my own at home	Never	Sometimes	Often	Always
6. Nothing is much fun anymore	Never	Sometimes	Often	Always
7. I feel scared when I have to take a test	Never	Sometimes	Often	Always
8. I feel worried when I think someone is angry with me	Never	Sometimes	Often	Always
9. I worry about being away from my parents	Never	Sometimes	Often	Always
10. I get bothered by bad or silly thoughts or pictures in my mind	Never	Sometimes	Often	Always
11. I have trouble sleeping	Never	Sometimes	Often	Always
12. I worry that I will do badly at my school work .	Never	Sometimes	Often	Always
13. I worry that something awful will happen to someone in my family	Never	Sometimes	Often	Always
14. I suddenly feel as if I can't breathe when there is no reason for this	Never	Sometimes	Often	Always
15. I have problems with my appetite	Never	Sometimes	Often	Always
16. I have to keep checking that I have done things right (like the switch is off, or the door is locked)	Never	Sometimes	Often	Always
17. I feel scared if I have to sleep on my own.	Never	Sometimes	Often	Always

18. I have trouble going to school in the mornings because I feel nervous or afraid	Never	Sometimes	Often	Always
19. I have no energy for things	Never	Sometimes	Often	Always
20. I worry I might look foolish	Never	Sometimes	Often	Always
21. I am tired a lot	Never	Sometimes	Often	Always
22. I worry that bad things will happen to me	Never	Sometimes	Often	Always
23. I can't seem to get bad or silly thoughts out of my head.	Never	Sometimes	Often	Always
24. When I have a problem, my heart beats really fast	Never	Sometimes	Often	Always
25. I cannot think clearly	Never	Sometimes	Often	Always
26. I suddenly start to tremble or shake when there is no reason for this	Never	Sometimes	Often	Always
27. I worry that something bad will happen to me	Never	Sometimes	Often	Always
28. When I have a problem, I feel shaky	Never	Sometimes	Often	Always
29. I feel worthless	Never	Sometimes	Often	Always
30. I worry about making mistakes	Never	Sometimes	Often	Always
31. I have to think of special thoughts (like numbers or words) to stop bad things from happening.	Never	Sometimes	Often	Always
32. I worry what other people think of me	Never	Sometimes	Often	Always
33. I am afraid of being in crowded places (like shopping centers, the movies, buses, busy playgrounds)	Never	Sometimes	Often	Always
34. All of a sudden I feel really scared for no reason at all	Never	Sometimes	Often	Always
35. I worry about what is going to happen	Never	Sometimes	Often	Always
36. I suddenly become dizzy or faint when there is no reason for this	Never	Sometimes	Often	Always
37. I think about death	Never	Sometimes	Often	Always
38. I feel afraid if I have to talk in front of my class	Never	Sometimes	Often	Always

My heart suddenly starts to beat too quickly for no reason	Never	Sometimes	Often	Always
I feel like I don't want to move	Never	Sometimes	Often	Always
I worry that I will suddenly get a scared feeling when there is nothing to be afraid of	Never	Sometimes	Often	Always
I have to do some things over and over again (like washing my hands, clearing or putting things in a certain order)	Never	Sometimes	Often	Always
I feel afraid that I will make a fool of myself in front of people	Never	Sometimes	Often	Always
I have to do some things in just the right way to stop bad things from happening	Never	Sometimes	Often	Always
I worry when I go to bed at night	Never	Sometimes	Often	Always
I would feel scared if I had to stay away from home overnight	Never	Sometimes	Often	Always
I feel restless	Never	Sometimes	Often	Always

APPENDIX F
School Refusal Assessment Scale-Child-Revised

1. How often do you have bad feelings about going to school because you are afraid of something related to school (for example, tests, school bus, teacher, fire alarm)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

2. How often do you stay away from school because it is hard to speak with the other kids at school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

3. How often do you feel you would rather be with your parents than go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

4. When you are not in school during the week (Monday to Friday), how often do you leave the house and do something fun?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

5. How often do you stay away from school because you will feel sad or depressed if you go?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

6. How often do you stay away from school because you feel embarrassed in front of other people at school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

7. How often do you think about your parents or family when in school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

8. When you are not in school during the week (Monday to Friday), how often do you talk to or see other people (other than your family)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

9. How often do you feel worse at school (for example, scared, nervous, or sad) compared to how you feel at home with friends?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

10. How often do you stay away from school because you do not have many friends there?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

11. How much would you rather be with your family than go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

12. When you are not in school during the week (Monday to Friday), how much do you enjoy doing different things (for example, being with friends, going places)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

13. How often do you have bad feelings about school (for example, scared, nervous, or sad) when you think about school on Saturday and Sunday?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

14. How often do you stay away from certain places in school (e.g., hallways, places where certain groups of people are) where you would have to talk to someone?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

15. How much would you rather be taught by your parents at home than by your teacher at school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

16. How often do you refuse to go to school because you want to have fun outside of school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

17. If you had less bad feelings (for example, scared, nervous, sad) about school, would it be easier for you to go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

18. If it were easier for you to make new friends, would it be easier to go to school?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

19. Would it be easier for you to go to school if your parents went with you?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

20. Would it be easier for you to go to school if you could do more things you like to do after school hours (for example, being with friends)?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

21. How much more do you have bad feelings about school (for example, scared, nervous, or sad) compared to other kids your age?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

22. How often do you stay away from people at school compared to other kids your age?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

23. Would you like to be home with your parents more than other kids your age would?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

24. Would you rather be doing fun things outside of school more than most kids your age?

0	1	2	3	4	5	6
Never	Seldom	Sometimes	Half The Time	Usually	Almost Always	Always

APPENDIX G
Multigroup Ethnic Identity Measure

In this country, people come from many different countries and cultures, and there are many different words to describe the different backgrounds or **ethnic groups** that people come from. Some examples of the names of ethnic groups are Hispanic or Latino, Black or African American, Asian American, Chinese, Filipino, American Indian, Mexican American, Caucasian or White, Italian American, and many others. These questions are about your ethnicity or your ethnic group and how you feel about it or react to it.

Please fill in: In terms of ethnic group, I consider myself to be _____

Use the numbers below to indicate how much you agree or disagree with each statement.

Strongly Disagree	Disagree	Agree	Strongly Agree	
1	2	3	4	
1. I have spent time trying to find out more about my ethnic group, such as its history, traditions, and customs.	1	2	3	4
2. I am active in organizations or social groups that include mostly members of my own ethnic group.	1	2	3	4
3. I have a clear sense of my ethnic background and what it means for me.	1	2	3	4
4. I think a lot about how my life will be affected by my ethnic group membership.	1	2	3	4
5. I am happy that I am a member of the group I belong to.	1	2	3	4
6. I have a strong sense of belonging to my own ethnic group.	1	2	3	4
7. I understand pretty well what my ethnic group membership means to me.	1	2	3	4
8. In order to learn more about my ethnic background, I have often talked to other people about my ethnic group.	1	2	3	4
9. I have a lot of pride in my ethnic group.	1	2	3	4
10. I participate in cultural practices of my own group, such as special food, music, or customs.	1	2	3	4

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